

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 12501</u>
BIRTH NO. <u>70 12501</u>		1. NAME OF DECEASED (Type or Print) <u>KINSEY, ELSIE JEAN</u>		
2. DATE AND HOUR OF DEATH <u>12/25/70</u> <u>12<sup>30</sup></u> <u>A.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>UNIVERSITY HOSPITAL</u>		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>FREDERICK</u>		5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY HOSPITAL</u>		
6. SEX <u>F</u>		7. RACE <u>W</u>		8. DATE OF BIRTH <u>7/2/08</u>
9. AGE (In years lost birthday) <u>62</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>FRANK RHUDE</u>		14. MOTHER'S MAIDEN NAME <u>IDA MURPHY</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>285-12-1573</u>		17. INFORMANT <u>TINA NUNNALLY</u>
18. <u>7/2/31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>RESPIRATORY ARREST</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>100% SUBLUXATION OF C6 OVER C7</u> <u>SEVERE RHEUMATOID ARTHRITIS</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>12/24</u> 19 <u>70</u> to <u>12/25</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>12/25</u> 19 <u>70</u> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>David M. Cook MD</u>		23B. DATE SIGNED <u>12/25/70</u>		23C. PHYSICIAN'S NAME (Type) <u>DEGREE</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12/28/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>OAKWOOD</u>
24D. LOCATION (City, town, or county) (State) <u>FREMONT OHIO</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 28 1970</u>		
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>W. Brooks Bulley, M.D.</u>		

1000

1000



70 12502

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12502

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CLARENCE JACKSON

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38 University Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

12

24

1970

9 p

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE Maryland B. COUNTY 1603

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

6-22-1926

10. AGE (In years last birthday)

44

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

Franklin St. 1600 W.

11. BIRTHPLACE (State or foreign country)

GLOUCESTER CO VA

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

ROMEO JACKSON

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

14B. KIND OF BUSINESS OR INDUSTRY

CONSTRUCTION

15. MOTHER'S MAIDEN NAME

Lillian RANDALL

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL SECURITY NO.

225-20-4828

18. INFORMANT

ADDRESS

Lillian Jackson 1931 Harcom Ave

19.

E965X

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Gunshot wound of chest  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

bar

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

511 N. Gilmore St.

22D. TIME  
OF INJURY  
(APPROX.)

12-24-70 8:35 p m.

22E. INJURY OCCURRED  
WHILE AT WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot while he stepped in line of fire  
of man who was shooting at girlfriend.  
and that on this basis, death in my opinionI certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-25-70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

24B. DATE

12/26/70

24C. NAME OF CEMETERY or CREMATORY

Zion Hill Bapt

24D. LOCATION (City, town, or county)

Gloucester Co VA

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 28 1970

25B. NAME OF REGISTRAR

Robert E. [Signature]

25C. FUNERAL DIRECTOR

[Signature]

ADDRESS

2813 Gilm St

50 15205

50 15205

F 230  
70 12503

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 12503

FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 1. NAME OF DECEASED (Type or Print) <b>Elmer H. Fugate, Jr</b>		2. DATE AND HOUR OF DEATH <b>12/22/70 5:50 a.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>31</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2636</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1101 Cavendish Way 21224</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/20/10</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAINTENANCE MECHANIC HOUSING AUTHORITY</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>BALTO. CITY</b>	9. AGE (In years last birthday) <b>60</b>
11. BIRTHPLACE (State or foreign country) <b>BALTO. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ELMER FUGATE</b>		14. MOTHER'S MAIDEN NAME <b>Estelle BURBAN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES ?</b>		16. SOCIAL SECURITY NO. <b>218-01-5729</b>	17. INFORMANT <b>BCH: Records</b> ADDRESS <b>Baltimore City Hospitals 4940 Eastern Ave. Balto. Md.</b>
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiogenic Shock</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Myocardial infarction</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>YES</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (we) <del>(the hospital)</del> attended the deceased from <b>11/19/70</b> to <b>12/22/70</b> , that (I) (we) <del>(we)</del> lost saw the deceased alive on <b>12/22/70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <b>H.S. Goldberg, M.D.</b> DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <b>12/22/70</b>
23C. PHYSICIAN'S NAME (Type) <b>H.S. Goldberg</b> DEGREE		23D. ADDRESS <b>4940 Eastern Ave. Balto., Md. 21224 Baltimore City Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>12-26-70</b>	24C. NAME OF CEMETERY or CREMATORY <b>BALTIMORE CEMETERY</b>	24D. LOCATION (City, town, or county) (State) <b>1101 CAVENDISH AVE. BALTO. MD</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 28 1970</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.S.</b>	25C. FUNERAL DIRECTOR <b>J. Walter Conklin</b> ADDRESS <b>5444 BELAIR RD.</b>	

POST DE

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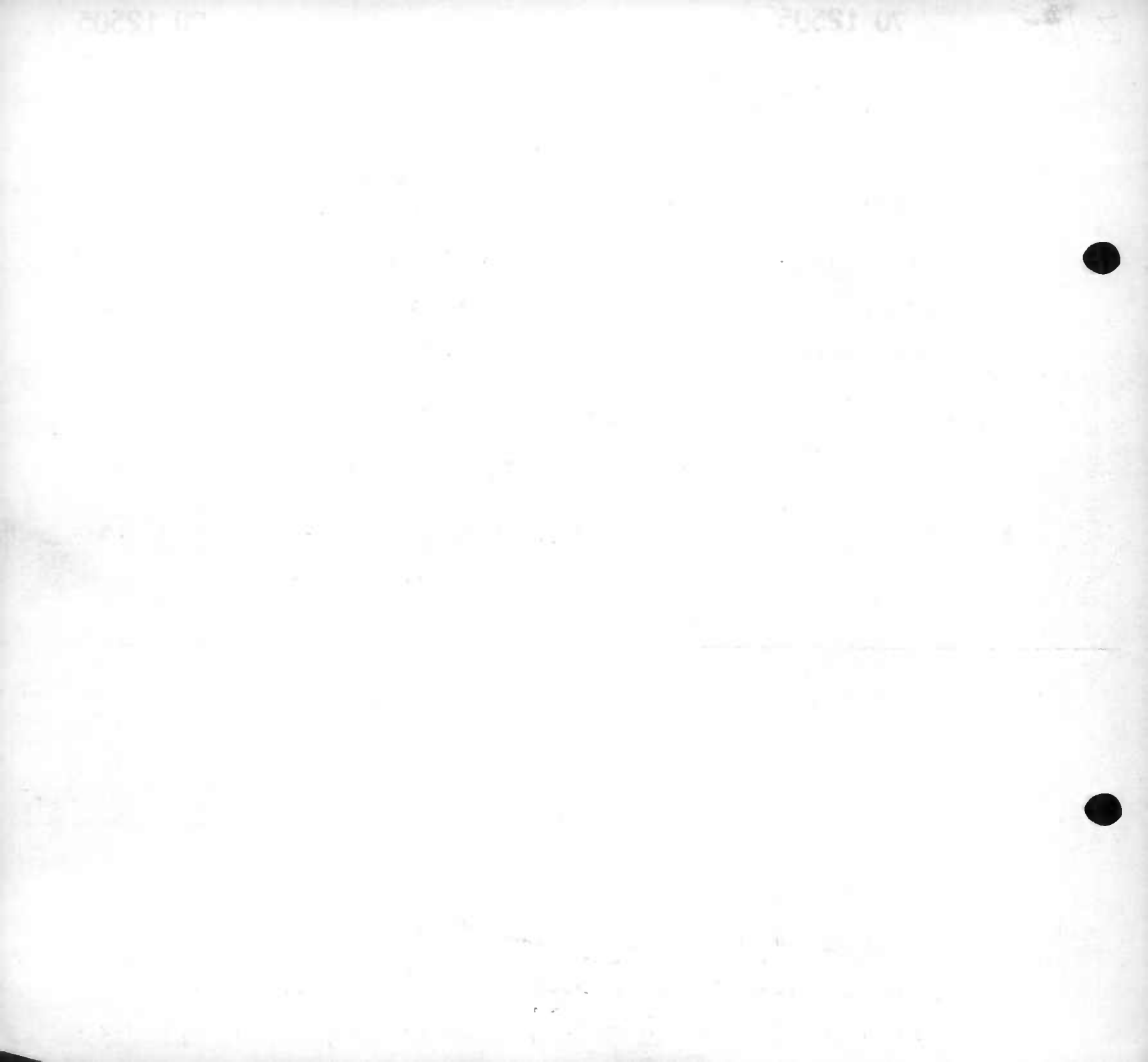
70 12504		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 12504	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) EMIL L. KOHLI			
2. DATE AND HOUR OF DEATH 12/23/70 7:5 P.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD LUTHERAN HOSPITAL OF MD			
4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) A. STATE MARYLAND B. COUNTY HARFORD				5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
C. CITY OR TOWN WILMERSVILLE D. INSIDE CITY LIMITS? BALTIMORE NO <input checked="" type="checkbox"/>				E. STREET AND NUMBER BOX 276A SEVERN ROAD			
8. DATE OF BIRTH 6/11/20 9. AGE (In years last birthday) 50				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Metal Y. M. C.			
11. BIRTHPLACE (State or foreign country) WIS				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Samuel Kohli				14. MOTHER'S MAIDEN NAME Rose Michael			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service Yes WWII				16. SOCIAL SECURITY NO. 388147133			
17. INFORMANT MARY KOHLI				ADDRESS ABOVE			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE PULMONARY EDEMA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE HEART FAILURE (B) DUE TO, OR AS A CONSEQUENCE OF: ADVANCED PULMONARY EMPHYSEMA (C) SECONDARY POLYCYTHEMIA							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Indefinitely medical examined		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR NO INJURY			
22. I certify that (I) (this hospital) attended the deceased from 12/21/70 to 12/23/70 that (I) (we) last saw the deceased alive on 12/23/70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE K George Thomas MD				23B. DATE SIGNED 12/23/70			
23C. PHYSICIAN'S NAME (Type) K GEORGE THOMAS MD				23D. ADDRESS LUTHERAN HOSPITAL OF MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/26/70		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		24D. LOCATION Glen Burnie Md.	
25A. DATE REC'D BY HEALTH DEPT. EC 28 1970		25B. NAME OF REGISTRAR Robert E. Taylor MD		25C. FUNERAL DIRECTOR Robert S. Bananas		ADDRESS Severna Park	



**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 12505</b>	
70 12505 CERTIFICATE OF DEATH					
BIRTH NO. <b>70 12505</b>					
1. NAME OF DECEASED (Type or Print) <b>JACOB F. ZIBRON</b>		2. DATE AND HOUR OF DEATH <b>Dec. 24, 1970</b>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>001504 OHMSTEAD ST.</b>		A. STATE <b>MD.</b>		B. COUNTY <b>2505</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>1504 Ohmstead ST.</b>					
5. SEX <b>M</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 6 - 1887</b>	9. AGE (In years last birthday) <b>83</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>	
13. FATHER'S NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Family</b>	
				ADDRESS <b>Same</b>	
18. <b>153.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <b>Respiratory Arrest</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Adenocarcinoma of the Colon</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>c. Wide spread metastasis</b> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>mins</b> <b>Months</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(I)</u> (this hospital) attended the deceased from <u>12</u> <u>1969</u> to <u>1</u> <u>1969</u> , that <u>(I)</u> (we) last saw the deceased alive on <u>Jan</u> <u>1970</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Donald M. Wood, MD</b>		23B. DATE SIGNED <b>12-24-70</b>		23C. PHYSICIAN'S NAME (Type) <b>DONALD M. WOOD, MD</b>	
23D. ADDRESS <b>South Baltimore General Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-28-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Highland Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. 21220, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 28 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>John H. HANN, 4200 Pennington Ave.</b>	
				ADDRESS	



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70 12506		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12506	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Paul L. Sellman</i>		2. DATE AND HOUR OF DEATH <i>12/24/70 6:30 A M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>2102</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>00 845 Washington Blvd</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>845 Washington Blvd.</i>	
5. SEX <i>M.</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/28/1947</i>	9. AGE (in years last birthday) <i>23</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Printer Products</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>William L. Sellman</i>		14. MOTHER'S MAIDEN NAME <i>Theresa D. Ulrich</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>216-52-1031</i>		17. INFORMANT <i>Mr. William L. Sellman</i>	
18. <i>391.21</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial failure</i>		<i>Sudden</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Myocarditis, Rheumatic</i>		<i>3 months</i>	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Congenital absence of mandible</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>3/22</i> 19 <i>52</i> to <i>12/24</i> 19 <i>70</i> that (I) ( <del>we</del> ) last saw the deceased alive on <i>12/17</i> 19 <i>70</i> and that (in my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>John P. Urlock Jr MD</i>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>12/24/70</i>	
23C. PHYSICIAN'S NAME (Type) <i>JOHN P. URLOCK JR MD</i>		23D. ADDRESS <i>1227 Washington Blvd</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/1/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>	
24D. LOCATION <i>Baltimore, Md.</i>		24E. NAME OF REGISTRAR <i>Robert E. Taylor</i>		24F. FUNERAL DIRECTOR <i>John J. Cowan &amp; Son Inc.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 28 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>John J. Cowan &amp; Son Inc.</i>	

(b)(7)(C)

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BALTIMORE CITY HEALTH DEPARTMENT

70 12507

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12507

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILBERT H. HINES

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

40 St. Agnes Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

12

24

1970

10:45p

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

BALTO. 5300

6. SEX

male

7. RACE

white

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

9/25/06

10. AGE (In years last birthday)

64

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

8 N. Beechwood Ave.

11. BIRTHPLACE (State or foreign country)

PA

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

SAMUEL HINES

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

MACHINIST

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

ANNA

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

✓

WW II

17. SOCIAL SECURITY NO.

21209-1197

18. INFORMANT

Tom Cockey

ADDRESS

CATONSVILLE, MD

19. 199.0

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Carcinomatosis  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

0

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)22E. INJURY OCCURRED  
WHILE AT WORK ☐  
NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an inquiry ☐ inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-25-70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

CREMATION

24B. DATE

12/26/70

24C. NAME of CEMETERY or CREMATORY

LEE FUNERAL HOME

24D. LOCATION (City, town, or county) (State)

Washington D.C.

25A. DATE REC'D BY HEALTH DEPT.

DEC 28 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

E.S. McNeil

ADDRESS

301 Frederick Rd  
BALTO MD 21208

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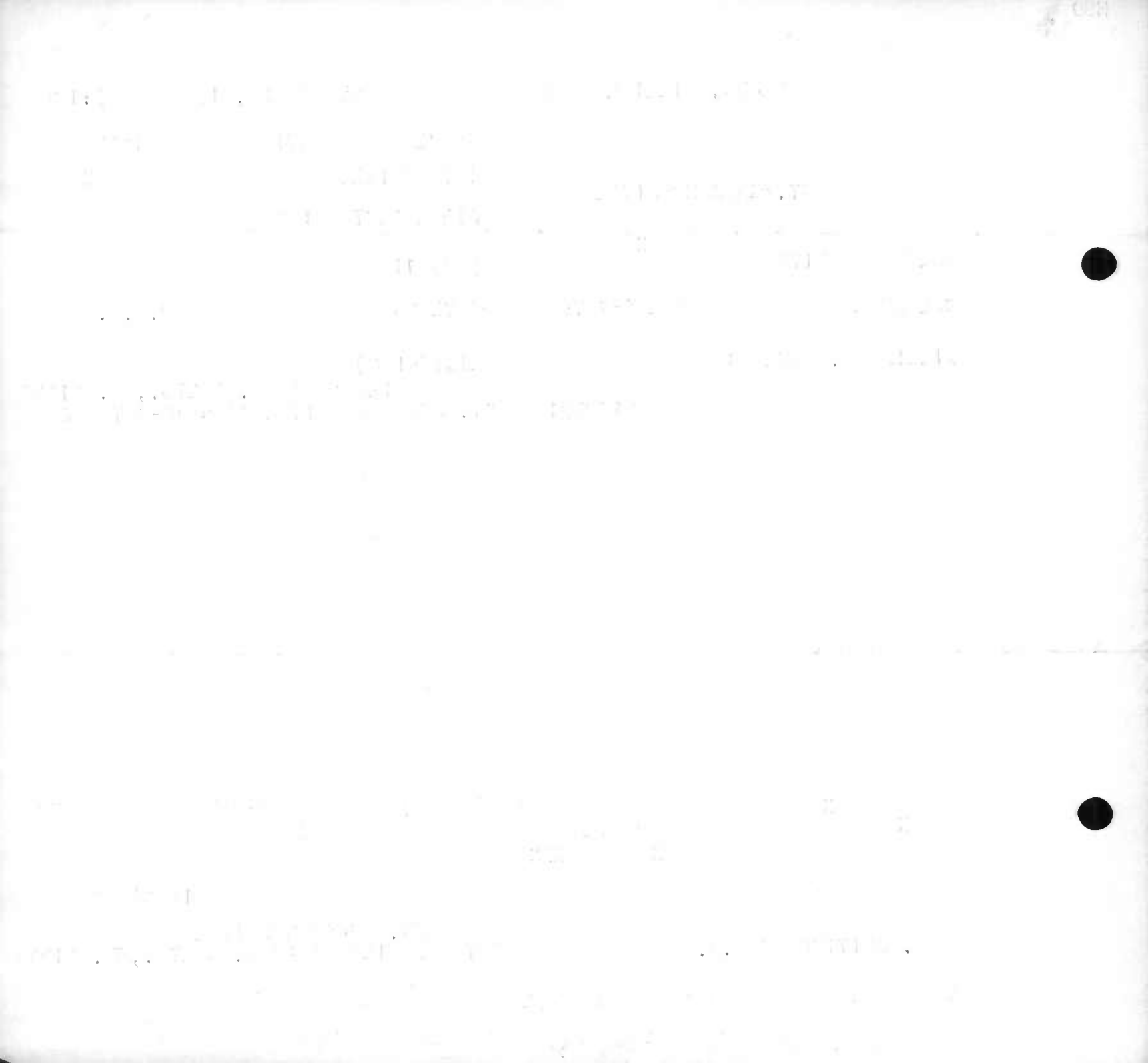
STATE OF TEXAS

70851 OF

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 70 12508	
BIRTH NO. 70 12508		CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) WEHLAND, WILLIAM HARVARD				2. DATE AND HOUR OF DEATH DECEMBER 24, 1970 3:10A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL				A. STATE MARYLAND		B. COUNTY BALTIMORE	
				C. CITY OR TOWN CATONSVILLE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER #14 LOCUST DRIVE			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 03 07 11	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY REAL ESTATE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM D. WEHLAND				14. MOTHER'S MAIDEN NAME ALICE (KING)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215073192		17. INFORMANT ADDRESS WILKENS AVES. BALTO., MD. 21229 ST. AGNES HOSPITAL RECORDS-CATON &			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Congestive Heart Failure and Chronic Renal Failure due to A.S.C.V.D.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 30 19 70 to DECEMBER 24 19 70 that (X) (we) lost saw the deceased alive on DECEMBER 24 19 70 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE S. Chittchang				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12 24 70	
23C. PHYSICIAN'S NAME (Type) S. CHITTCHANG M.D.				23D. ADDRESS ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTO., MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/28/70		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK BALTO. MD.		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. DEC 28 1970		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12509		BALTIMORE CITY HEALTH DEPARTMENT		70 12509	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		J. HARDY, WILMER		DEC. 22, 1970 7:45 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION HOUSE IN THE PINES BELVEDERE 2525 W. BELVEDERE AVENUE BALTIMORE MARYLAND 21215				A. STATE MARYLAND	
				B. COUNTY	
C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3320 MILFORD AVE.	
5. SEX male	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/8/01	9. AGE (In years last birthday) 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder		10B. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME John F. Hardy				14. MOTHER'S MAIDEN NAME Grace E. Scheiblein	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-10-9996A		17. INFORMANT R. Francis Hardy 4200 Groveland Ave.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arterio-sclerotic Heart Disease	
				(B) DUE TO, OR AS A CONSEQUENCE OF: Ventral Hernia	
				(C) DUE TO, OR AS A CONSEQUENCE OF: Chronic Prostatitis	
19A. DATE OF OPERATION None				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from June 27 1967 to Dec. 22 1970 that (I) (we) last saw the deceased alive on Dec. 20 1970 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) (did not) view the body after death.					
23A. SIGNATURE Dr. Earl L. Chambers				23B. DATE SIGNED 12/23/70	
23C. PHYSICIAN'S NAME (Type) DR. EARL CHAMBERS				23D. ADDRESS 100-W. Cold Spring Lane - Balto - Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-24-1970		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge	
24D. LOCATION Pikesville Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 28 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR G. Howard Strong 3207 W. North Ave.,			

PAGE 1

10/10/10

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 70 12510	
BIRTH NO. 70 12510		CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <u>Jenkins, Carroll Francis</u>				2. DATE AND HOUR OF DEATH <u>12/22/70</u> <u>3 20 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>North Charles General Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>AA</u> C. CITY OR TOWN <u>Linthicum</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>900 Lynvue Road</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/15/04</u>	9. AGE (in years last birthday) <u>66</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Expediter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Benjamin Jenkins</u>				14. MOTHER'S MAIDEN NAME <u>Koerner</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>213 09 9823</u>		17. INFORMANT <u>Mrs. Chast</u>		ADDRESS	
18. <u>410.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Aspiration pneumonia</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Acute MI</u> <u>Polynovitis</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5d.</u> <u>7d.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>12/17</u> 19 <u>70</u> to <u>12/22</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>12/22</u> 19 <u>70</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <u>Shelly L. Hall M.D.</u>				23B. DATE SIGNED <u>Dec 22, 1970</u>			
23C. PHYSICIAN'S NAME (Type) <u>Shelly L. Hall M.D.</u>				23D. ADDRESS <u>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/26/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 28 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, R.D.</u>		25C. FUNERAL DIRECTOR <u>R.V. Singleton/Glen Burnie, Md.</u>		ADDRESS	

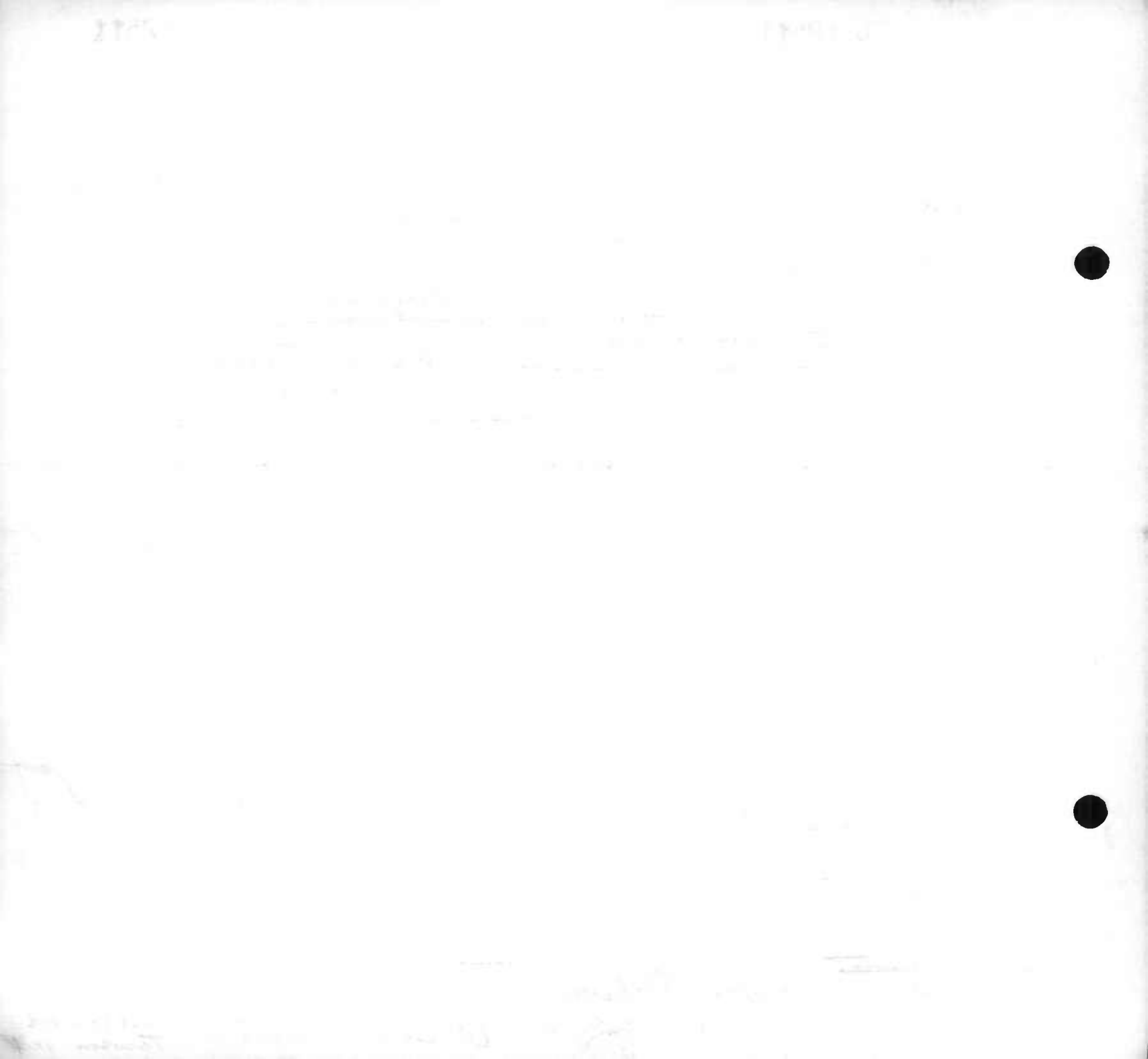
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
70 12511					X REG. NO. 70 12511				
BIRTH NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <u>Mildred Baheh</u>					12-21-70 6:30 p.m.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>12 Sinai Hospital</u>					A. STATE <u> Md. </u>		B. COUNTY <u> Baltimore </u>		
					C. CITY OR TOWN <u> Baltimore </u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>2123 Texas Ave</u>									
5. SEX <u> F </u>	6. RACE <u> W </u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u> 2-26-18 </u>	9. AGE (In years last birthday) <u> 52 </u>	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> housewife </u>					10B. KIND OF BUSINESS OR INDUSTRY <u> Home, not available </u>		11. BIRTHPLACE (State or foreign country) <u> Virginia </u>		
12. CITIZEN OF WHAT COUNTRY? <u> U. S. A. </u>									
13. FATHER'S NAME <u> J. Elliott McGehee </u>					14. MOTHER'S MAIDEN NAME <u> Alberta - Jenkins </u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u> No </u>					16. SOCIAL SECURITY NO. <u> not available </u>		17. INFORMANT <u> Woody Funeral Home </u>		
ADDRESS <u> Richmond, Virginia </u>									
18. <u> 20571 </u>					CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE <u> hemorrhage </u> DUE TO, OR AS A CONSEQUENCE OF:				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) <u> bone marrow suppression days </u> DUE TO, OR AS A CONSEQUENCE OF:				
(C) <u> chronic myelogenous leukemia 4 years </u>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u> 6 </u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u> No </u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u> Dec 7 </u> 19 <u> 70 </u> to <u> Dec 21 </u> 19 <u> 70 </u> that (I) (we) last saw the deceased alive on <u> Dec 21 </u> 19 <u> 70 </u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u> Marcia Wittenburg, M.D. </u>					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u> 12-21-70 </u>	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
DEGREE					DEGREE				
24A. BURIAL OR CREMATION, REMAINS (Specify)		24B. DATE <u> 12/24/70 </u>		24C. NAME OF CEMETERY OR CREMATORY <u> Oakwood </u>		24D. LOCATION (City, town, or county) (State) <u> Richmond Virginia </u>			
25A. DATE REC'D BY HEALTH DEPT. <u> DEC 28 1970 </u>		25B. NAME OF REGISTRAR <u> Robert E. Taylor, R.D. </u>		25C. FUNERAL DIRECTOR <u> Wm Cook-Brooks Towson </u>		ADDRESS <u> 1050 York Rd Towson, Md </u>			



70 12512

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 12512

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>L. ANNIE ANNAL PURNELL</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2123 Callow Ave.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 18 1970 6:10 p.m.</b>	
6. SEX <b>female</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>7/4/13</b>		10. AGE (In years lost birthday) <b>57</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>	
13. FATHER'S NAME <b>Unknown</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME <b>Unknown</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Mrs. Gaythue Clark 503 W. Lafayette</b>	
19. CAUSE OF DEATH <b>412.2</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive & arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12-19-70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/26/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Cty., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 28 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Wm C March</b>		ADDRESS <b>928 E. North Ave.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
70 12518 BIRTH NO. 12513 W.					70 12518 REG. NO. 12513					
1. NAME OF DECEASED (Type or Print) William Spencer					2. DATE AND HOUR OF DEATH 12-23-70 12:15 AM M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION MT. SINAI Nursing Home 904613 Park Heights Ave					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1903 C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 195. Fulton Ave					
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-11-0900	9. AGE (in years last birthday) 70	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labourer			10B. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Thomas Spencer					14. MOTHER'S MAIDEN NAME Lucy					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No			16. SOCIAL SECURITY NO. 247-09-1122		17. INFORMANT ADDRESS LELIA KING 195. FULTON AVE					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					CAUSE OF DEATH Bilateral Cerebral Thrombosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks					
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Dec 17 1970 to Dec 23 1970 that (I) (we) lost saw the deceased alive on Dec 22 1970 and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.										
23A. SIGNATURE Louis T. Lavy					23B. DATE SIGNED Dec 24 - 1970					
23C. PHYSICIAN'S NAME (Type) LOUIS T. LAVY					23D. ADDRESS 3502 W. Rogers Ave Baltimore Md					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/29/70		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		24D. LOCATION Balto Md.		24E. LOCATION (City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT. DEC 28 1970			25B. NAME OF REGISTRAR Robert E. Farber, M.D.			25C. FUNERAL DIRECTOR Wm C MARSH 928 E MORTH AVE			ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 1.5em;">70 12514</span>				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <span style="font-size: 1.5em;">70 12514</span>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">KREPPS, MR. GEORGE</span>					2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">12/21/70</span> <span style="float: right;">4:35 A.M. M.</span>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">35 CHURCH HOME AND HOSPITAL 100 N. BROADWAY, BALTIMORE, MARYLAND</span>					4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <span style="font-size: 1.2em;">BALTO.</span> B. COUNTY <span style="font-size: 1.2em;">BALTO.</span> C. CITY OR TOWN <span style="font-size: 1.2em;">7838 ROCKBOURN ROAD</span> D. INSIDE CITY LIMITS? <span style="font-size: 1.2em;">5300</span> YES <input type="checkbox"/> NO <input type="checkbox"/>				
5. SEX <span style="font-size: 1.2em;">MALE</span> 6. RACE <span style="font-size: 1.2em;">WHITE</span> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <span style="font-size: 1.2em;">10/20/89</span> 9. AGE (In years last birthday) <span style="font-size: 1.2em;">81</span>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">RETIRED FOREMAN</span> 10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">STEEL</span>					11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">PENNSYLVANIA</span>				
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>					13. FATHER'S NAME <span style="font-size: 1.2em;">JAMES KREPPS</span>				
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">MATILDA CHICKS</span>					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">YES WWII</span>				
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">292 09 2358</span>					17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mrs. MABEL ALLEN, 800 Old North Point Rd.</span>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">4361 I</span>					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Cerebral Vascular accident</span>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">II</span>					(B) <span style="font-size: 1.2em;">generalized Arteriosclerosis</span> DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">years</span>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">14 days</span>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (H) (this hospital) attended the deceased from <span style="font-size: 1.2em;">12-7-1970</span> 1970 to <span style="font-size: 1.2em;">12-21</span> 1970 that (H) (we) last saw the deceased alive on <span style="font-size: 1.2em;">12-21</span> 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <span style="font-size: 1.2em;">Abdus Samad</span> MD DEGREE					23B. DATE SIGNED				
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">ABDUS SAMAD</span> MD DEGREE					23D. ADDRESS <span style="font-size: 1.2em;">Church Home &amp; Hospital Balt MD</span>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
<span style="font-size: 1.2em;">BURIAL</span>		<span style="font-size: 1.2em;">23 Dec 70</span>		<span style="font-size: 1.2em;">Cath. Land Cemetery</span>		<span style="font-size: 1.2em;">Baltimore Co., MD.</span>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
<span style="font-size: 1.2em;">DEC 28 1970</span>		<span style="font-size: 1.2em;">Robert E. Taylor, RD.</span>		<span style="font-size: 1.2em;">ULLRICH FUNERAL HOME, DUNDALK, MD.</span>					

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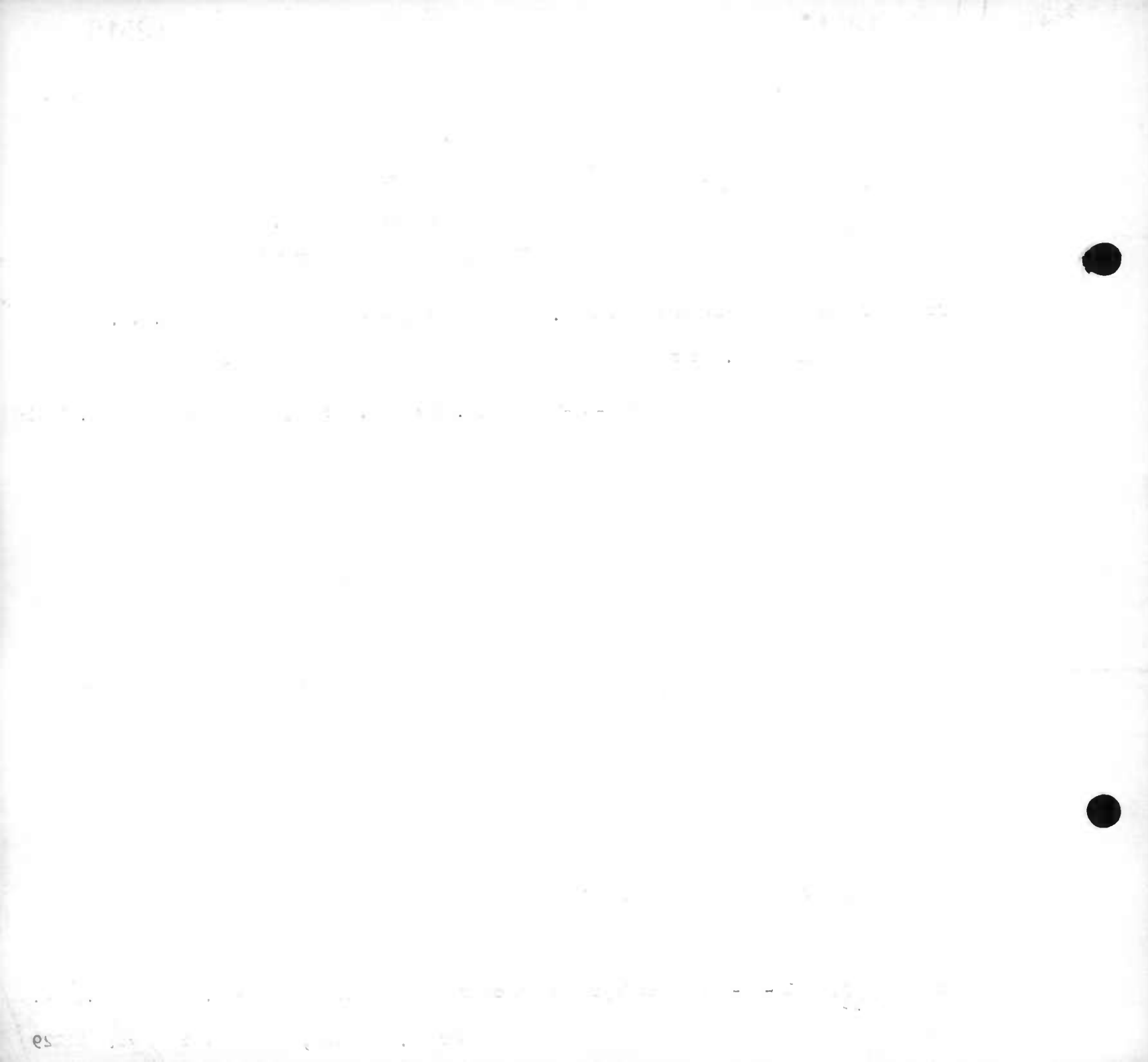
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">70 12515</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">70 12515</span> <span style="font-size: 1.5em;">BIRTH NO.</span> </div>					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Melvin L. Welsh</span>			2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> <span><span style="font-size: 1.2em;">12/20/70</span></span> <span><span style="font-size: 1.2em;">7:45</span> P. M.</span> </div>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">40 St. Agnes Hospital</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.2em;">2572</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">2655 Marbourne Ave.</span>		
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">10/8/11</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">59</span>	10. Under 1 Yr. <input type="checkbox"/> 11. Under 24 Hrs. <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Truck Driver</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Joseph Digan Co.</span>	11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">William E. Welsh</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Wilhelmina Conway</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">212-05-2073</span>	17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mrs. Leona J. Welsh, 2655 Marbourne Rd. 21230</span>		
18. CAUSE OF DEATH <div style="display: flex;"> <div style="flex: 1;">                     DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                      (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                       ANTECEDENT CAUSES                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                       II                      OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                 </div> <div style="flex: 2;"> <span style="font-size: 1.5em;">Acute Bleeding -</span>                      (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.5em;">Swimming, Cardiac Arrest</span>                      (B) DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.5em;">Multiple Contusions</span>                      (C) <span style="font-size: 1.5em;">Cerebral Aneurysm - Rupture</span> </div> <div style="flex: 0.5; text-align: center;">                     APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  <span style="font-size: 1.5em;">1 hr.</span> </div> </div>					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">4-23-68</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">Stomach - Cancer</span>		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work <input type="checkbox"/> Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">[Signature]</span>			23B. DATE SIGNED  Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">ALEXANDER MEHA MD</span>			23D. ADDRESS <span style="font-size: 1.2em;">St Agnes Hospital</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">12-24-1970</span>	24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Meadowridge Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Washington Blvd. Howard Co., Md.</span>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Howard H. Hubbard, 4107 Wilkens Ave. 21229</span>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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70 12516

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 12516

BIRTH NO. 70 12516		2. DATE AND HOUR OF DEATH 12-22-70 7:35 P.M.	
1. NAME OF DECEASED (Type or Print) Bessie Wittler		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Balto. Co.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 70 Hilton Nursing Home 3313 Poplar Street Baltimore, Md. 21216		C. CITY OR TOWN Catonsville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 116 Paradise Ave.	
5. SEX F	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1885 9. AGE (In years lost birthday) 85
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME William Jenkins		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-03-2943A	
17. INFORMANT Raymond L. Jenkins		ADDRESS 116 Paradise Ave.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) A.S.C.U.D. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 1970 to 12-22-1970 that (I) (we) last saw the deceased alive on 12-22-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Dr. Barbu Calin		23B. DATE SIGNED 12-24-70	
23C. PHYSICIAN'S NAME (Type) Dr. Barbu Calin		23D. ADDRESS 831 Poplar Grove Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/24/70	
24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 28 1970		25B. NAME OF REGISTRAR Robert E. Taber, Jr.	
25C. FUNERAL DIRECTOR Ambrose Inc		ADDRESS 1328 Sulphur Sp Rd.	

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BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 12517

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CHARLES L. KING</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>806 W. Monument St.</b>		3. DATE PRONOUNCED DEAD Month <b>12</b> Day <b>22</b> Year <b>1970</b> Hour <b>6:25 p</b> M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1701</b>			
6. SEX <b>male</b>	7. RACE <b>negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>4-12-1933</b>		10. AGE (In years last birthday) <b>37</b>		E. STREET AND NUMBER <b>414 Orchard St.</b>			
11. BIRTHPLACE (State or foreign country) <b>Mt. Airy, North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles King</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Mary Alice King</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		17. SOCIAL SECURITY NO.		18. INFORMANT <b>National Funeral Home</b>		ADDRESS <b>Mt. Airy, N.C. 824 N. Main St.</b>	
19. <b>571.8</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE Fatty liver DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12-23-70</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-29-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Mountain View Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Mt. Airy, North Carolina</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 28 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens Street</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X REG. NO.		70 12518	
1. NAME OF DECEASED (Type or Print) <i>Braxton Moses Sr.</i>				2. DATE AND HOUR OF DEATH <i>12-22 10:05p.m.</i>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>					
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Balt. Gen Hosp</i>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>43</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>m</i>		6. RACE <i>W N</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-25-12</i>		9. AGE (In years last birthday) <i>58</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Moses</i>				14. MOTHER'S MAIDEN NAME <i>Theresa Butler</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No.</i>				16. SOCIAL SECURITY NO. <i>250-03-1726</i>		17. INFORMANT <i>Mrs. Mary Moses</i>			
						ADDRESS <i>110 Elizabeth Ave</i>			
18. <i>412.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Hypertensive Cardiovascular Disease</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Chronic Obstructive Pulmonary Disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>no</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>12-14 1970</i> to <i>12-22 1970</i> , that (I) (we) last saw the deceased alive on <i>12-22 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Daniel Howell</i>				DEGREE Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>12-23-70</i>			
23C. PHYSICIAN'S NAME (Type) <i>Daniel Howell</i>				DEGREE		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/28/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Balt. Md</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 28 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, R.D.</i>		25C. FUNERAL DIRECTOR <i>Moeton &amp; Dyth F.H.</i>		ADDRESS <i>1701 Laurens St</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 12519</b>	
BIRTH NO. <b>70 12519</b>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>PARKER Fannie</b>			2. DATE AND HOUR OF DEATH <b>12/22/70 6:25 a.m.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>The Johns Hopkins Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>2540 Sycamore Avenue</b>		
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/1/82</b>	9. AGE (In years last birthday) <b>88</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Samuel Snowden</b>			14. MOTHER'S MAIDEN NAME <b>Rachel Harris</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Irene Watson</b> ADDRESS <b>2524 Sycamore Avenue</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Complete Heart Block</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Myocardial Infarction</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>12/18</b> 1970 to <b>12/22</b> 1970, that (X) (we) last saw the deceased alive on <b>12/22</b> 1970 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Anthony Jennings, M.D.</b>				23B. DATE SIGNED <b>12-27</b>	
23C. PHYSICIAN'S NAME (Type) <b>Anthony Jennings, M.D.</b>		23D. ADDRESS <b>The Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12-26-70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>A.A. Co., Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 28 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Robert J. Dyett</b> ADDRESS <b>1701 Laurens Street</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12520	
BIRTH NO. 70 12520					
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <b>MARY WILLIAMS</b>			2. DATE AND HOUR OF DEATH <b>Friday, Dec 25, 1970, 2:25 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>md.</b> B. COUNTY <b>Baltimore City</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Lutheran Hospital of Md.</b>			C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>F</b>			6. RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>2-24-18</b>			9. AGE (in years last birthday) <b>52</b>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator (Cont. Can. Co.)</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>P.C.</b>		11. BIRTHPLACE (State or foreign country) <b>P.C.</b>
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <b>Warren Boyd</b>		
14. MOTHER'S MAIDEN NAME <b>Martha Leathers</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>218-01-7859</b>			17. INFORMANT <b>Boyd William 521 Willow Parkway</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Advanced Carcinomatosis</b> <b>Cancer Lungs.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>12-25-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-7-70</b> to <b>12-25-70</b> that (I) (we) last saw the deceased alive on <b>12-25-70</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M.R. Elmore H.D. DEGREE</b>			23B. DATE SIGNED <b>12-25-1970</b>		23C. PHYSICIAN'S NAME (Type) <b>MANDON H. RUSTON M.D. DEGREE</b>
23D. ADDRESS <b>Lutheran Hospital</b>			24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>12/28/70</b>			24C. NAME of CEMETERY or CREMATORY <b>Oakland Memorial Park</b>		
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>			25A. DATE REC'D BY HEALTH DEPT. <b>DEC 28 1970</b>		
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>			25C. FUNERAL DIRECTOR <b>Joseph J. Rocks</b>		
25D. ADDRESS <b>1304 N. Central St.</b>			25E. DATE <b>DEC 28 1970</b>		

Received of Mr. J. H. Smith  
the sum of \$100.00  
for the purchase of land  
in the town of Smith  
County, Mo.

Witness my hand and seal  
this 1st day of May

1881

Attest my hand and seal  
this 1st day of May  
1881

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		X		70 12521	
BIRTH NO. 70 12521		CERTIFICATE OF DEATH		REG. NO. 70 12521	
1. NAME OF DECEASED (Type or Print) <b>FRANK GOLOMBOWSKI</b>			2. DATE AND HOUR OF DEATH <b>Dec. 24, 1970 6:30 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>35 CHURCH HOME AND HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO.</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1741 BROOKVIEW RD. (22)</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-19-91</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>		
11. BIRTHPLACE (State or foreign country) <b>MARYLAND POLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>PETER GOLOMBOWSKI</b>			14. MOTHER'S MAIDEN NAME <b>KATHERINE GORALSKI</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>215-28-7594</b>		17. INFORMANT <b>Elizabeth Madry (Daughter)</b> ADDRESS <b>(Same)</b>
18. <b>412.41-204.0</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Possible Acute Lymphocytic Leukemia - ad</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Cardiac arrest after 1 hr.</b> <b>Chronic obstructive pulmonary disease</b> <b>Due to, or as a consequence of: (Chronic?)</b> <b>Due to, or as a consequence of: disease</b> <b>(C) -----</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 21</b> 19 <b>70</b> to <b>Dec 27</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>Dec 27</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Rolando A. Mendoza</b>			23B. DATE/SIGNED <b>12/27/70</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>ROLANDO A. MENDOZA, M.D.</b>			23D. ADDRESS <b>100 N. Broadway St. Balto, MD. (31)</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/30/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS CEMETERY</b>	
24D. LOCATION (City, town, or county) <b>BALTIMORE, MD.</b>		24E. (State) <b>MD.</b>		24F. (Country) <b>USA</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 28 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Jaber, R.D.</b>		25C. FUNERAL DIRECTOR'S ADDRESS <b>GEORGE A. WEBER-705 S. ANN ST. #21231</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12522		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12522	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Pedvin, Henry T.		Between 7:30 pm 12/24/70 and 11:30 am 12/25/70	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 <del>Union</del> 5223 Anthony Ave Baltimore, Maryland			Maryland Baltimore 2632		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			5223 Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			5223 Anthony Avenue		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (in years last birthday)
male	white			01-23-85	85
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED TRUCK DRIVER				Maryland	USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John T. Pedvin			Virginia Hayden		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
Unknown NO			214-03-7495A		Maryle Wienpeg 905 N. Kenwood Baltimore
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
412.41			Arteriosclerotic Cardiovascular Disease		
I (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 12/06/70 19 to 12/16/70 19 that (I) (we) last saw the deceased alive on 12/16/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
H. Earl Cotman				12/25/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
H. Earl Cotman, M.D.				Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		12/28/70		Mt. Carmel Cemetery - Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 28 1970		Robert E. Taylor, Jr.		LEONARD J. RUCK, INC. Balto. Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 70 12523	
BIRTH NO. 70 12523					
1. NAME OF DECEASED (Type or Print) <b>BROWN, Charles</b>			2. DATE AND HOUR OF DEATH <b>12/22/70 7:05 a.m.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2653</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 The Johns Hopkins Hospital</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>4001 Sinclair Lane</b>		
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/4/87</b>	9. AGE (In years last birthday) <b>83</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bartender.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Tavern.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Charles Brown</b>		
14. MOTHER'S MAIDEN NAME <b>Carrie Fireover</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>218-01-6860</b>			17. INFORMANT <b>Mrs. Eva Brown</b>		
ADDRESS <b>4001 Sinclair Lane</b>			18. CAUSE OF DEATH <b>Pulm. Emphysema</b>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Emphysema</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>? ~ 30 min</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Emphysema</b>		
(B) DUE TO, OR AS A CONSEQUENCE OF:			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/17</b> 19 <b>70</b> to <b>12/22</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>12/22</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Anthony Jennings</b>				23B. DATE SIGNED <b>12/22/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Anthony Jennings, M.D.</b>				23D. ADDRESS <b>The Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/24/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Holy Redeemer</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 28 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Tabor</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Luck, Inc.</b>			
ADDRESS <b>5305 Harford Rd</b>					



Released by MCB-13-10

## FUNERAL DIRECTOR: IMPORTANT

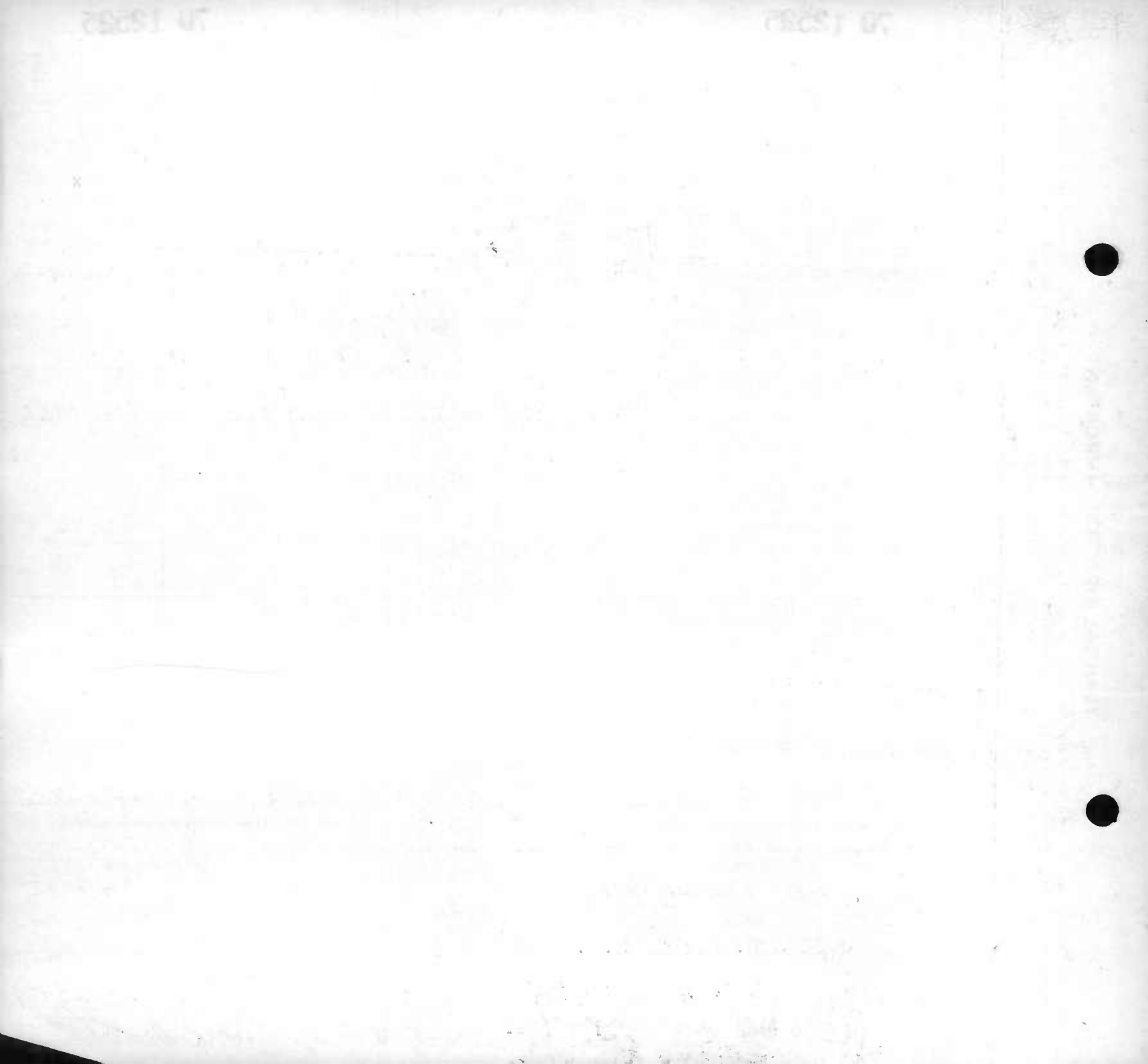
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12524		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12524	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Joseph J. Petersam (Petersam)		2. DATE AND HOUR OF DEATH 12/21/70 330 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hosp		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. 831 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3303 Woodstock Ave			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/18/85	9. AGE (In years last birthday) 85	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Insurance Co.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Henry Petersam <del>Walter Petersam</del>		14. MOTHER'S MAIDEN NAME <del>Walter Petersam</del> Katherine Martin			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-20-6134A		17. INFORMANT Mr. F. Alfred Petersam (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH (A) IMMEDIATE CAUSE GI Bleeding DUE TO, OR AS A CONSEQUENCE OF: Uremia (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Ex @ Hip (3 weeks ill)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 12/1/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ex @ Hip		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) above address	
21D. TIME OF INJURY (APPROX.) 11/26/70		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? PE fall over rug at	
22. I certify that (I) (this hospital) attended the deceased from 11/24/70 19 to 12/21 19 70 that (I) (we) lost saw the deceased alive on 12/21 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Omar P. Crothers MD		23B. DATE SIGNED 12/21/70		23C. PHYSICIAN'S NAME (Type) Omar P. Crothers MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/24/70		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
25A. DATE REC'D BY HEALTH DEPT. DEC 28 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>70 12525</b>
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BLANCHÉ</b>		
2. DATE AND HOUR OF DEATH <b>12-14-70 11:35 A.M.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>VA</b> B. COUNTY <b>V-43</b>		5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
C. CITY OR TOWN <b>PARKSLEY</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>JOHNS HOPKINS HOSPITAL</b>		
8. DATE OF BIRTH <b>3-06-88</b>		9. AGE (In years last birthday) <b>82</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>SAMUEL Smith</b>		14. MOTHER'S MAIDEN NAME <b>FRANCES Colonna</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>231 70 8752</b>		17. INFORMANT ADDRESS <b>LOUISE Middleton-daughter</b>
18. <b>482.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Chronic lung Disease</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Hemophilus Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF:		
(C) _____				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) <del>this hospital</del> attended the deceased from <b>12-7</b> 19 <b>70</b> to <b>12-14</b> 19 <b>70</b> , that (I) <del>was</del> last saw the deceased alive on <b>12-14</b> 19 <b>70</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>not</del> view the body after death.				
23A. SIGNATURE <b>Joseph O. Moore, MD</b>		23B. DATE SIGNED <b>12-14-70</b>		23C. PHYSICIAN'S NAME (Type) <b>JOSEPH O. MOORE M.D.</b>
23D. ADDRESS		23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-16-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Liberty Cemetery, PARKSLEY, VA 23421</b>
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 28 1970</b>		
25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Barton D. Allard</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12526	
<div> <div>70 12526</div> <div>CERTIFICATE OF DEATH</div> </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <u>George Howard Reightler</u>			2. DATE AND HOUR OF DEATH <u>12/23/70</u> <u>6:00</u> <u>P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2102</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore Gen.</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Namoun St.</u>			E. STREET AND NUMBER <u>1217 W. Ostdend St.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>10/2/20</u>	9. AGE (In years lost birthday) <u>50</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Trucking Co.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Nelson B. Reightler</u>		
14. MOTHER'S MAIDEN NAME <u>LENA AC BRIGGS</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes W.W.II</u>		
16. SOCIAL SECURITY NO. <u>—</u>			17. INFORMANT <u>Mrs Lena Reightler</u>		
18. <u>5-21-01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic Obstructive Pulmonary Disease</u> (B) <u>Cirrhosis of Liver</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>—</u>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Chronic Alcoholism</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/28/70</u> 19 to <u>12/23/70</u> 19 that (I) (we) last saw the deceased alive on <u>12/23/70</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ronald H. Nislop, M.D.</u>			23B. DATE SIGNED <u>12/23/70</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>RONALD H. NISLOP M.D.</u>			23D. ADDRESS <u>South Baltimore Gen.</u>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/28/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>London Park Cem.</u>	
24D. LOCATION <u>Baltimore, Md.</u>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 28 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>John J. Carver &amp; Son, Inc.</u>	
25D. ADDRESS <u>901 N. Hollins St. Balt. Md. 21201</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 12527</u>	
BIRTH NO. <u>70 12527</u>		1. NAME OF DECEASED (Type or Print) <u>HELEN HOLMES</u>			
2. DATE AND HOUR OF DEATH <u>12/23/70</u> <u>12:45</u> P M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Granada Nursing Home</u> <u>4017 Liberty Heights Ave., Balto.</u>			
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		5. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>233 E. University Parkway</u>			
5. SEX <u>Female</u>	6. RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/9/90</u>	9. AGE (in years last birthday) <u>80</u>	10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing School</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>William Shafer</u>		14. MOTHER'S MAIDEN NAME <u>Raechele Barnhart</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Thomas R. Holmes</u> ADDRESS <u>7112 Mani la Ave 21207</u>	
18. <u>153.01</u> CAUSE OF DEATH "DISEASE OR CONDITION DIRECTLY LEADING TO DEATH" (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE - <u>carcinoma of secum</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/13/70</u> 19 to <u>12/23/70</u> 19 that (I) (we) last saw the deceased alive on <u>12/23/70</u> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>12/23/70</u>		23C. PHYSICIAN'S NAME (Type) <u>HOLLIS SEUNARINE, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/26/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. STATE <u>Maryland</u>		24F. ADDRESS <u>Stansbury Funeral Home 6411 Windsor Mill</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 28 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Talley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Stansbury Funeral Home</u>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>70 12528</b>	
BIRTH NO. <b>70 12528</b>		1. NAME OF DECEASED (Type or Print) <b>Baby Boy Mule</b>		2. DATE AND HOUR OF DEATH <b>12/23/70</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital</b>			C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>6856 Duluth Ave. # 21224.</b>		
5. SEX <b>M</b> <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/19/70</b>	9. AGE (In years last birthday) <b>3</b>	10. Under 1 Yr. Months: <b>12</b> Days: <b>12</b> Hours: <b>12</b> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
13. FATHER'S NAME <b>Thomas Mule</b>			14. MOTHER'S MAIDEN NAME <b>Patricia Kurek</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Thomas Mule : 6856 Duluth Ave. # 21224.</b>	
18. <b>776181</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Respiratory distress Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF: <b>and Respiratory failure</b> (B) <b>Central Nervous System involvement</b> DUE TO, OR AS A CONSEQUENCE OF: <b>U</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-19-1970</b> to <b>12-23-1970</b> that (I) (we) last saw the deceased alive on <b>Dec. 23, 1970</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>N. J. SHAH</b>				23B. DATE SIGNED <b>12/23/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>N. J. SHAH</b>				23D. ADDRESS <b>Mercy Hospital, Baltimore, Md. 21202</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-24-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Sacred Heart Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Ba. Co., Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>DEC 28 1970</b>		24F. NAME OF REGISTRAR <b>Robert E. Farber, R.D.</b>	
24G. FUNERAL DIRECTOR <b>Charles S. Geiler</b>		24H. ADDRESS <b>901 S. Conkling St. Balto., 21224, Md.</b>		24I. DATE <b>12/23/70</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12529		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12528	
BIRTH NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Dickens, Henry</i>			2. DATE AND HOUR OF DEATH <i>12/15/70 11:45 A.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General</i> <i>43</i> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <i>1-8-71</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2301</i>		
5. SEX <i>m</i>			6. RACE <i>N</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>
13. FATHER'S NAME <i>Lafayette Dickens</i>			14. MOTHER'S MAIDEN NAME <i>Flora Lawrence</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>North Dickens 127 W Cross St</i>
18. <i>15-7-9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>CAUSE OF DEATH</i> <i>Cardio-Respiratory failure</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>20 to Septicemia</i> <i>CA Pancreas</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>Few weeks</i>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>3-12-11-70</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>JAUNDICE CAUSE</i>		20A. AUTOPSY (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11-17-70</i> to <i>12-15-70</i> that (I) (we) last saw the deceased alive on <i>12-15-70</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Charles Vorasubin, M.D.</i>			23B. DATE SIGNED <i>12/15/70</i>		23C. PHYSICIAN'S NAME (Type) <i>VARAH VORASUBIN, M.D.</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>12/21/70</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt Auburn</i>
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 28 1970</i>			25B. NAME OF REGISTRAR <i>Robert E. Taylor, R.A.</i>		25C. FUNERAL DIRECTOR <i>1123 W Montgomery St</i>
24D. LOCATION (City, town, or county) (State) <i>Balto City</i>			25D. ADDRESS <i>SOUTH BALTIMORE GEN. HOSP. BALTO, Md.</i>		

V.S. 153

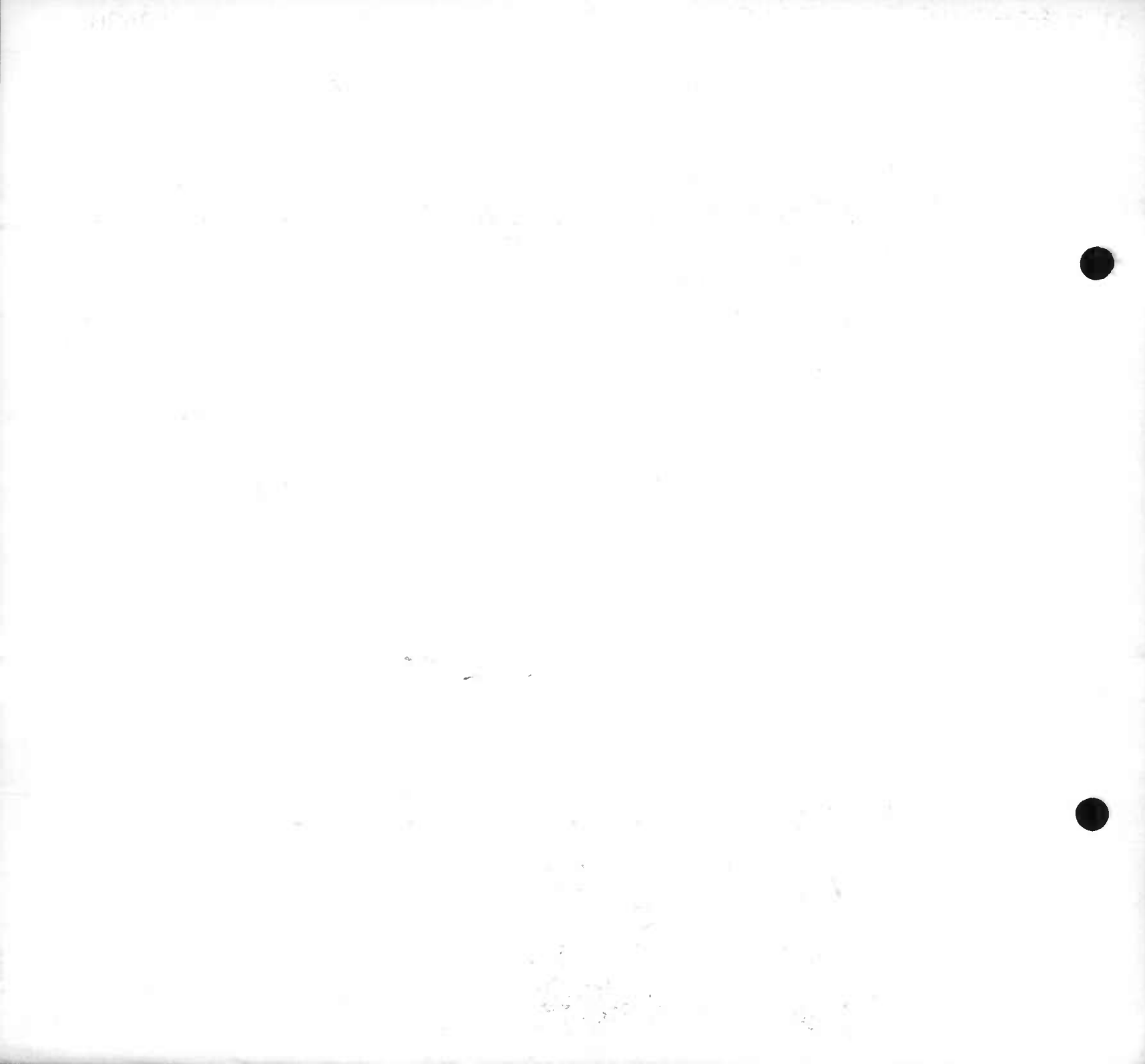
1-8-71

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 12530</b>	
<div style="display: flex; justify-content: space-between;"> <span>M 620-09-21 djs</span> <span><b>70 12530</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED <i>Marecki, Thomas</i> <b>THOMAS M. MARECKI</b>			
2. DATE AND HOUR OF DEATH <i>9:45 AM 12/23/70</i>		M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hospitals</i>		A. STATE <i>Maryland</i>		B. COUNTY <i>26, 36</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>4940 Eastern Avenue Balto. Md. 21224</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>1349 S. Drew St. 21224</i>					
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-25-24</i>	9. AGE (in years last birthday) <i>46</i>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Veteran Blind Cutter</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Standard Veneer Company</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S. A.</i>		13. FATHER'S NAME <i>Alex Marecki</i> <b>Alexander Marecki</b>			
14. MOTHER'S MAIDEN NAME <i>Hedwick Pakulski</i> <b>Ida Pakulski</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> WW II			
16. SOCIAL SECURITY NO. <i>216-20-0826</i>		17. INFORMANT <i>Baltimore City Hospitals Records</i> ADDRESS <i>4940 Eastern Avenue Baltimore, Maryland 21224</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>I</b> <i>162-1</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebro-vascular</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Ca of lung &amp; metas 1 year</i>			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/8/70</i> 19__ to <i>12/25/70</i> 19__ that (I) (we) last saw the deceased alive on <i>12/25</i> 19__ <i>70</i> and that <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Seremiah Dowel</i>		23B. DATE SIGNED <i>12/25/70</i>		23C. PHYSICIAN'S NAME (Type) <i>Seremiah Dowel</i>	
23D. ADDRESS <i>Baltimore City Hospitals</i>		23E. ADDRESS <i>4940 Eastern Avenue Baltimore, Maryland 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/29/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. Stanislaus</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 28 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Tabor, M.D.</i>		25C. FUNERAL DIRECTOR <i>M.F. SADOWSKI &amp; SONS, 1808 EASTERN AVE</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>70 12531</u>	
BIRTH NO. <u>70 12531</u>				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <u>ANNIE M. BUTERBAUGH</u>				2. DATE AND HOUR OF DEATH <u>21 Dec 1970</u>   <u>10<sup>30</sup></u> P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>4 Maryland General Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>HARFORD</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Forest Hill</u> 21050 D. STREET ADDRESS (If rural, give location) <u>1604 E. Belvue Dr.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>25 Nov 1900</u>	9. AGE (In years last birthday) <u>70</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Homekeeping</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Frank Thornton</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Atwood</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-32-9707</u>		17. INFORMANT <u>Joseph B. Buterbaugh</u>		ADDRESS <u>Forest Hill, Md. 21050</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>BRONCHOPNEUMONIA + PULM. EMBOLISM</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Right pleuro-pneumectomy</u> <u>Fibrothorax 2° Empyema, Atelectasis, &amp; Bronchiectasis</u>				(A) <u>Hemorrhage, Right Pleura</u> DUE TO (B) <u>Right pleuro-pneumectomy</u> DUE TO (C) <u>Fibrothorax 2° Empyema, Atelectasis, &amp; Bronchiectasis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Total Obstruction of Right Pulmonary Artery</u>							
19A. DATE OF OPERATION <u>21 DEC 1970</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Fibrothorax 2° EMPYEMA</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>5 DEC 1970</u> to <u>21 DEC 1970</u> , that (2) (we) last saw the deceased alive on <u>21 DEC 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Wm Gregory Bruce</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>21 Dec 70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Wm Gregory Bruce</u>				23D. ADDRESS M.D. <u>Lassahn Funeral Home 7401 Belair Rd. 21236</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-24-70</u>		24C. NAME of CEMETERY or CREMATORY <u>Belair Memorial Gardens</u>		24D. LOCATION (City, town, or county) (State) <u>Belair Harford Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 28 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, Jr.</u>		25C. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd. 21236</u>	

18251 05

18251 05



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 70 12532

BIRTH NO. 70 12532

1. NAME OF DECEASED

(Type or Print)

JOHN HENRY MEYERS Sr.

2. DATE AND HOUR OF DEATH

12/23/70

1645 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31

Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md. Baltimore

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

701 Oakleigh Beach Avenue 21222

5. SEX

Male

6. RACE

White

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

12/25/02

9. AGE (In years last birthday)

67

If Under 1 Yr. If Under 24 Hrs. Min.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Frederick

14. MOTHER'S MAIDEN NAME

Sophia Douglas

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

215-05-8844

17. INFORMANT

BCH: Records

ADDRESS

4940 Eastern Avenue  
Baltimore, Md. 21224

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CARDIAC ARREST

(B)

DUE TO, OR AS A CONSEQUENCE OF:

MESENTERIC ARTERY THROMBOSIS

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MINUTES

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

ASHD, PERIPHERAL VASCULAR DISEASE

19A. DATE OF OPERATION

12/21/70

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

MESENTERIC ARTERY THROMBOSIS

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/20/70 to 12/23/70 that (I) (we) last saw the deceased alive on 12/23/70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Ivens LaFlore M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

12/23/70

23C. PHYSICIAN'S NAME (Type)

Ivens LaFlore M.D.

23D. ADDRESS

4940 Eastern Avenue  
Baltimore, Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-26-70

24C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 28 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Thelma E. Hoffmann

ADDRESS

3218 Hudson St.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

12533		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12538	
70 12538		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LENA SINCLAIR		12/23/70	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  00 814 S. BOULDIN ST.			A. STATE MARYLAND		
			B. COUNTY 2611		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 814 S. BOULDIN ST.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/2/1890	9. AGE (in years last birthday) 80
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOHN SCHMIDT			14. MOTHER'S MAIDEN NAME MARGARET		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214 01 4630 D		17. INFORMANT Mr. John H. Sinclair - 814 S. Bouldin St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 412.41 1 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Generalized Arthritis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1946 to Dec 23 1970 that (I) (we) last saw the deceased alive on Dec 22 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Jason H. Gaskel, M.D.				23B. DATE SIGNED 12-24-70	
23C. PHYSICIAN'S NAME (Type) JASON H. GASKEL M.D.				23D. ADDRESS 6375 Conkline St. Baltimore Md 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-26-70		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn	
				24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 28 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Thelma A. Hoffmann 3218 Hudson St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P 452

70 12534

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

70 12534

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Frank J. Polanka*

2. DATE AND HOUR OF DEATH

*Dec. 24 1970*

*11:29 a.m.*

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

*33*

*John Hopkins Hospital*

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

*Maryland*

C. CITY OR TOWN

*Balto.*

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

*718 N. Madeira St. Balto. 21205*

5. SEX

*M*

6. RACE

*White*

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

*Dec. 1 1898*

9. AGE (In years lost birthday)

*72*

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Painter*

10B. KIND OF BUSINESS OR INDUSTRY

*House Painting*

11. BIRTHPLACE (State or foreign country)

*Maryland*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*Matthew Polanka*

14. MOTHER'S MAIDEN NAME

*Antoinette Stack*

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

*Yes*

*W.W. I*

16. SOCIAL SECURITY NO.

*217-16-4529*

17. INFORMANT

*Helen M. Polanka 718 N. Madeira St. Balto 5*

ADDRESS

18.

*412.31*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

*Coronary Heart Disease*

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

*2 yrs.*

(B)

DUE TO, OR AS A CONSEQUENCE OF:

*Emphysema and Asthma*

*10 yrs.*

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from *October 16* 19 *70* to *Dec. 24* 19 *70* that (I) (we) lost saw the deceased alive on *November 19* 19 *70* and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ~~did~~ (did not) view the body after death.

23A. SIGNATURE

*Israel Rosen M.D.*

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

*12/26/70*

23C. PHYSICIAN'S NAME (Type)

*Israel Rosen*

23D. ADDRESS

*2413 E. Monument St. Balto. Md. 21205*

24A. BURIAL CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*12/28/70*

24C. NAME of CEMETERY or CREMATORY

*Holy Redeemer Cemetery*

24D. LOCATION

*Balto. Md.*

Isotel

25A. DATE REC'D BY HEALTH DEPT.

*DEC 28 1970*

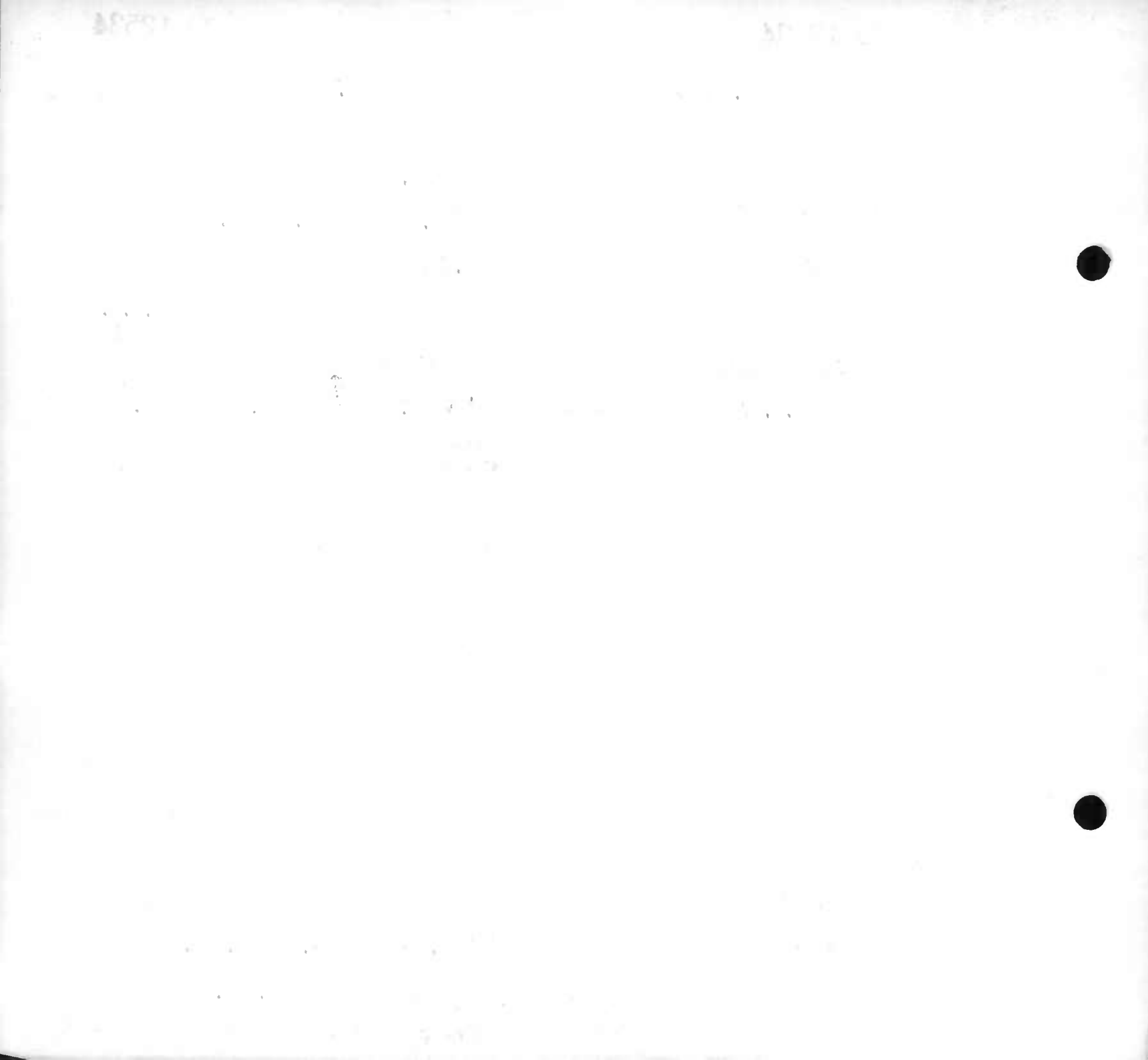
25B. NAME OF REGISTRAR

*Robert E. Fisher, R.A.*

25C. FUNERAL DIRECTOR

*Philip J. Cruch 1211 Chesaco Ave.*

ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12535</u>
70 12535 Carroll to. Md				CERTIFICATE OF DEATH
BIRTH NO. <u>70 12535</u>		1. NAME OF DECEASED (Type or Print) <u>Joseph LEE MAY</u>		
2. DATE AND HOUR OF DEATH <u>12-22-70 3:40 A.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Baby Boy May</u>		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>CARROLL</u>		5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37 Mercy Hospital</u>		
C. CITY OR TOWN <u>WESTMINSTER</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER <u>RD #7</u>				
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-21-70</u>	9. AGE (in years last birthday) <u>10</u> <u>4</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ROBERT L. MAY</u>		
14. MOTHER'S MAIDEN NAME <u>VADA CARBAUGH</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT <u>ROBERT L. MAY, WESTMINSTER MD</u>		
18. <u>70601</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>Cardiorespiratory Arrest</u>		
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>No Intracranial hemorrhage</u>		
		(C) <u>Depressed fracture, left frontal</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Breech delivery</u>		
19A. DATE OF OPERATION <u>12/21/70</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Depressed fracture</u>	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>12/21</u> 19 <u>70</u> to <u>12/22</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Johnny Eufemio</u> M.D.		23B. DATE SIGNED <u>12/22/70</u>		23C. PHYSICIAN'S NAME (Type) <u>JOHNNY EUFEMIO M.D.</u>
23D. ADDRESS <u>Mercy Hospital</u>				
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>12/23/70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>MEADOWBRANCH CEMETERY</u>	24D. LOCATION (City, town, or county) (State) <u>WESTMINSTER, MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 28 1970</u>	25B. NAME OF REGISTRAR <u>Robert E. Tabery, R.A.</u>	25C. FUNERAL DIRECTOR <u>J. E. Myers Jr.</u> ADDRESS <u>Westminster, Md.</u>		

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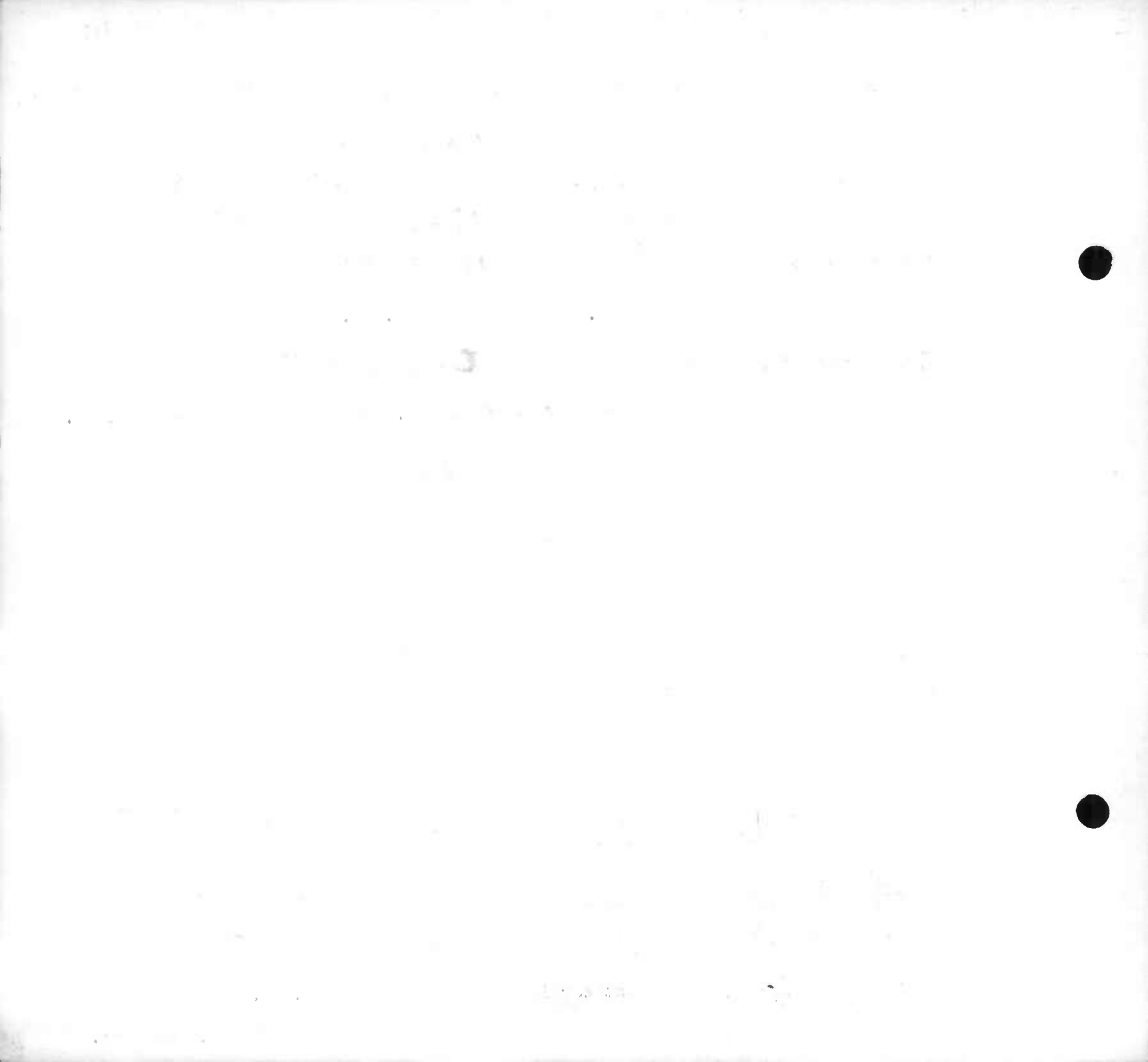
1933



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department CERTIFICATE OF DEATH				REG. NO. <u>70 12536</u>
BIRTH NO. <u>70 12536</u>		1. NAME OF DECEASED (Type or Print) <u>EDER, ANDREW MICHAEL</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>12-23-70</u> <u>12<sup>01</sup> MIDNIGHT</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SOUTH BALTIMORE GENERAL HOSPITAL</u> <u>43</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2303</u>		
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Meat Co.</u>		8. DATE OF BIRTH <u>10-30-00</u> 9. AGE (In years last birthday) <u>70</u>
13. FATHER'S NAME <u>JOSEPH F. (Dec)</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE COOK (Dec)</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		6. SOCIAL SECURITY NO. <u>215-09-4367A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
18. <u>250,917-154.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ACIDOSIS</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>DIABETES MELLITUS -</u> <u>POST-OPERATIVE</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ACIDOSIS</u> (B) <u>DIABETES MELLITUS -</u> DUE TO, OR AS A CONSEQUENCE OF: <u>POST-OPERATIVE</u> (C) <u>CARCINOMA OF THE RECTUM</u>		
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>CARCINOMA OF THE RECTUM</u>				
19A. DATE OF OPERATION <u>12-18-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CARCINOMA RECTUM</u>		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>12-10-1970</u> to <u>12-23-1970</u> that (I) (we) last saw the deceased alive on <u>12-23-1970</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>A. Villafania</u>		23B. DATE SIGNED <u>12-23-70</u>		23C. PHYSICIAN'S NAME (Type) <u>ARTEMIO A. VILLAFANIA</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12 26 70</u>		24C. NAME of CEMETERY or CREMATORY <u>Cathedral</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 28 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Mc Cully</u>
24D. LOCATION (City, town, or county) <u>Balto. Md.</u>		24E. ADDRESS <u>130 E. Fort Ave.</u>		



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70 12537

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 12537

BIRTH NO. 70-18824

REG. NO.

1. NAME OF DECEASED (Type or Print) MARK A. CHADWELL		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Baltimore General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 24 1970 12:55p M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Oct. 17, 1970		10. AGE (in years lost birthday) 2	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Arlie Chadwell		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2.404	
15. MOTHER'S MAIDEN NAME Gail Morris		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Arlie Chadwell	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Sudden Death in Infancy (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED: 12-25-70 ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12 26 70	
24C. NAME OF CEMETERY or CREMATORY Glen Haven		24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 28 1970		25B. NAME OF REGISTRAR Robert E. [unclear]	
25C. FUNERAL DIRECTOR McGully		ADDRESS 130 E. Fort Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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70 12538

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 12538

BIRTH NO. 70 12538		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 12538	
1. NAME OF DECEASED (Type or Print) CLIFTON E. BRADFORD			2. DATE AND HOUR OF DEATH 22 DEC 1970 11:55 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSPITAL 43			A. STATE MARYLAND		B. COUNTY 2402
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 1223 RIVERSIDE AVE					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-17-47	9. AGE (In years lost birthday) 23	10. Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME Lineman		10B. KIND OF BUSINESS OR INDUSTRY Elec. Co.	11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME CLAUDE Bradford			14. MOTHER'S MAIDEN NAME MARY GROVE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS HOSPITAL CHART		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CHRONIC PYELONEPHRITIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10 DECEMBER 19 70 to 22 DECEMBER 19 70 that (I) (we) last saw the deceased alive on 22 DECEMBER 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gary A. Belaga, M.D.			23B. DATE SIGNED 22 DEC 1970		
23C. PHYSICIAN'S NAME (Type) GARY A. BELAGA, M.D.			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12 26 70		24C. NAME OF CEMETERY OR CREMATORY Crestlawn	
24D. LOCATION Howard Co. Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. DEC 28 1970		25B. NAME OF REGISTRAR Robert E. Jarber, R.D.		25C. FUNERAL DIRECTOR Mc Cully 130 E. Fort Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12539</u>	
70 12539				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>GEORGE LESNY</u>		2. DATE AND HOUR OF DEATH <u>12/22/70</u> <u>3</u> <u>P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2631</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>90</u> House in the Pines			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER House in the Pines (Belair Road)		
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/22/93</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Crown Cork &amp; Seal</u>		11. BIRTHPLACE (State or foreign country) <u>Ukrainian</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			13. FATHER'S NAME <u>unknown</u>		
14. MOTHER'S MAIDEN NAME <u>unknown</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>Army WW 2</u> <u>220-07-5319</u>		
16. SOCIAL SECURITY NO. <u>220-07-5319</u>			17. INFORMANT <u>6017 Winthrop Ave.</u> ADDRESS <u>Samuel F. Seitz, brother-in-law</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>188X I</u> [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Chronic Renal System - dysfunctions</u>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Uremia</u> (B) <u>Bilateral ureteral obstruction</u> (C) <u>Transfused - all Carcinoma of Bladder</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u> <u>weeks</u> <u>unknown</u> <u>years</u>
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>5/19/61</u> to <u>12/22/70</u> that (I) ( <del>was</del> ) last saw the deceased alive on <u>12/21/70</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>Albert B. Bradley</u>			23B. DATE SIGNED <u>12/22/70</u>		23C. PHYSICIAN'S NAME (Type) <u>DEGREE</u>
23D. ADDRESS			23E. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/24/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 28 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Schmune Funeral Home 3331</u>			

Cod-470 N.H. 5834 B-141n Rd. Admitted

4/30/61 JT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO.

70 12540

BIRTH NO. 70 12540

1. NAME OF DECEASED  
(Type or Print)

HILDA VERONICA SPENCE

2. DATE AND HOUR OF DEATH

12/21/70

1:00 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)  
A. STATE B. COUNTY

Md. 21205

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

923 N. Janney Street

5. SEX

female

6. RACE

white

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

10/11/1895

9. AGE (In years  
last birthday)

75

10. Under 1 Yr. 11. Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Lorenzo Triplett

14. MOTHER'S MAIDEN NAME

Susan Winsor

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS 21237

Ruth Rathel, dght. 7930 Bridge Ave.

18.

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CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

Myocardial Infarction

(B) Antecedent Cause  
DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerotic Coronary Artery Disease

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐

Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb 19 60 to Dec 19 70  
that (I) (we) last saw the deceased alive on Dec 1 19 70 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.

23. SIGNATURE

John G. Orth, M.D.

Attending  
Phys. ☒

Med.  
Director ☐

Staff  
Phys. ☐

23B. DATE SIGNED

12/22/70

23C. PHYSICIAN'S  
NAME (Type)

John G. Orth, M. D.

23D. ADDRESS

Rosedale Medical Center

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12/23/70

24C. NAME OF CEMETERY or CREMATORY

Moreland Memorial Park

24D. LOCATION

(City, town, or county)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 28 1970

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

ADDRESS

3331 Brehms Lane

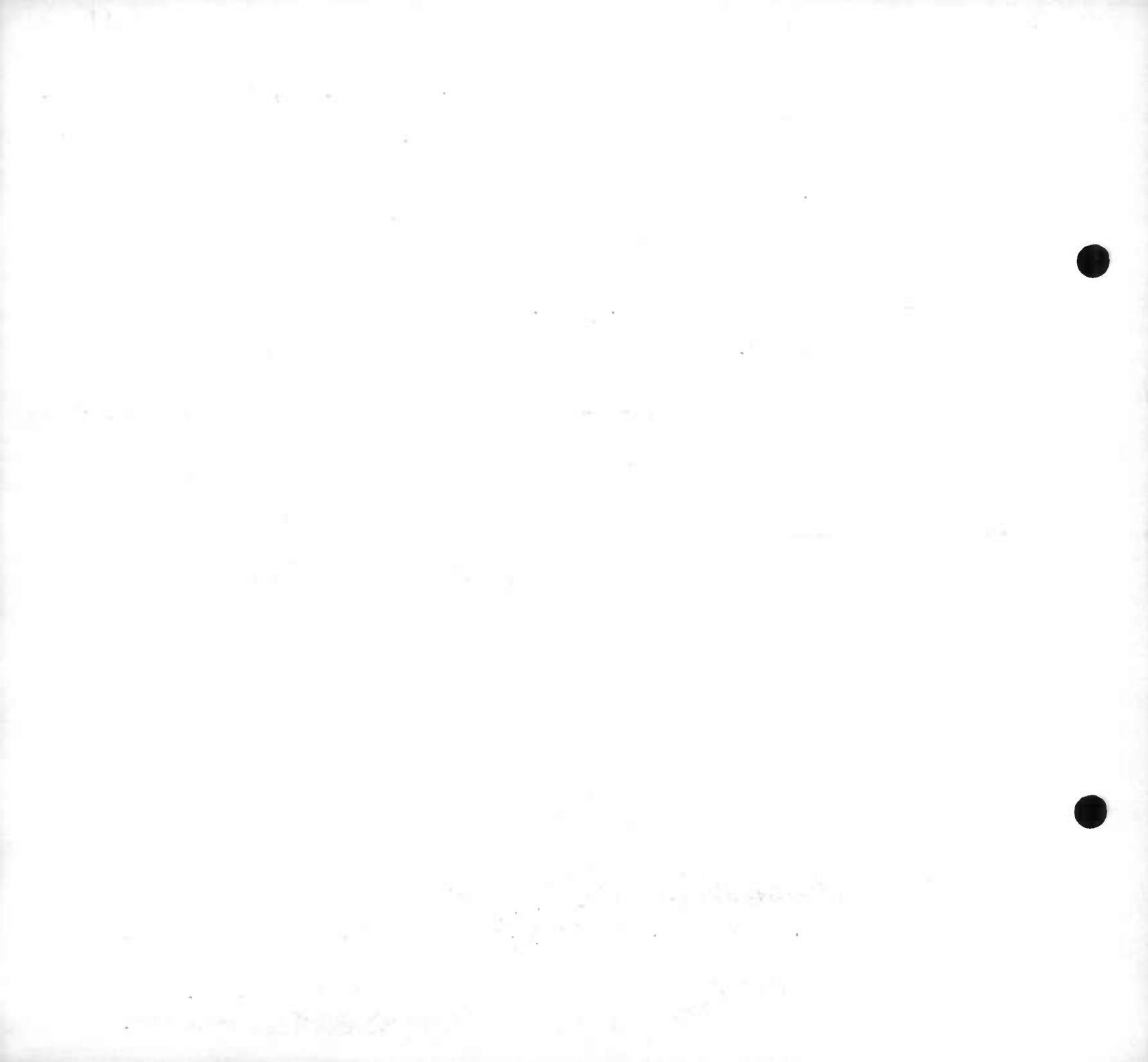


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 12541

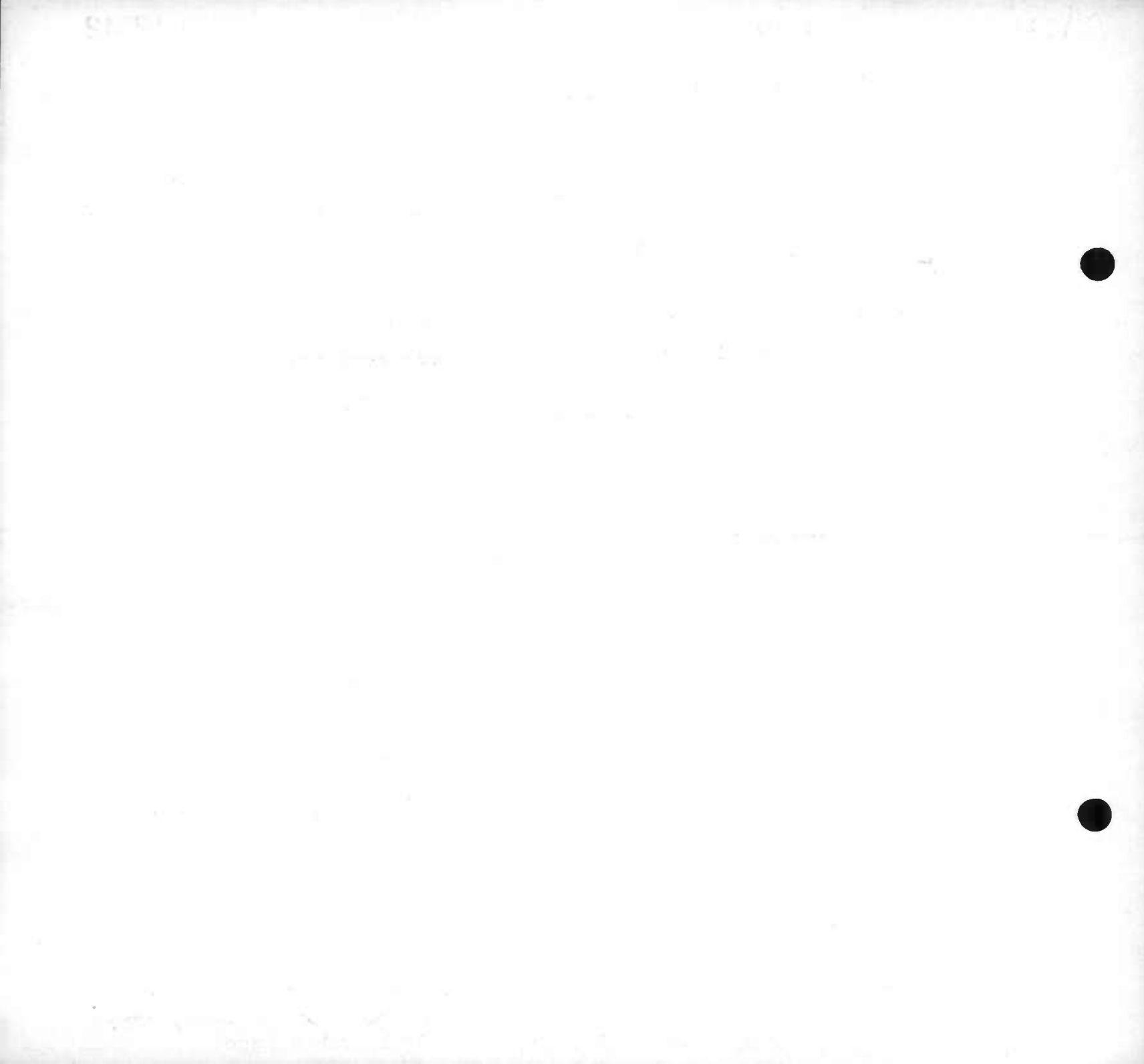
BIRTH NO. 70 12541		2. DATE AND HOUR OF DEATH Dec. 19, 1970 p. M.	
1. NAME OF DECEASED (Type or Print) WALTER MELVILLE MERCER, SR.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md., 21224 B. COUNTY 2714	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 219 N. Kenwood Avenue		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX male 6. RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/7/1900 9. AGE (In years lost birthday) 70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret-internal Revenue		11. BIRTHPLACE (State or foreign country) Maryland	
10B. KIND OF BUSINESS OR INDUSTRY Fed. Govt.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George M. Mercer		14. MOTHER'S MAIDEN NAME Martha Frank	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-10-4396	
17. INFORMANT Elizabeth Baxter Mercer, wife, above		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 1918XY1230.7 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio respiratory failure	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Glioblastoma re parietal	
(C) Diabetes mellitus			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (usually medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1965 19 to 1970 that (I) (we) last saw the deceased alive on Dec 17 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Dr. Charles C. MacMinn M.D. DEGREE		23B. DATE SIGNED Dec 22, 1970	
23C. PHYSICIAN'S NAME (Type) Dr. Charles C. MacMinn		23D. ADDRESS 2900 E. Baltimore Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/23/70	
24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 28 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 3331 Brehms Lane	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12542</u>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <u>70 12542</u></span> <span style="font-size: 1.2em;">CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print) <u>MacIacara, Margaret</u>			2. DATE AND HOUR OF DEATH <u>12/22/70</u> <u>2:55 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hosp.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>841</u>		
5. SEX <u>F</u>			6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Grief Clothiers</u>		8. DATE OF BIRTH <u>04-05-97</u>
13. FATHER'S NAME <u>Edmund Emminger</u>			11. BIRTHPLACE (State or foreign country) <u>MARYLAND Baltimore</u>		9. AGE (In years last birthday) <u>73</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>215-12-3161A</u>			16. SOCIAL SECURITY NO. <u>215-12-3161A</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>
17. INFORMANT <u>Chart</u>			ADDRESS <u>Louis Ma ciacara, husband, above</u>		
18. <u>4-31-91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebro vascular accident</u> <u>due to haemorrhage</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) _____ (C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/22/70</u> to <u>12/22/70</u> and that (I) (we) last saw the deceased alive on <u>12/21/70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>I. Cheikh</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>ISSAM CHEIKH</u>				23D. ADDRESS <u>Union Memorial Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/24/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery, Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 28 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, R.D. 1</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u>	
ADDRESS <u>3331 Brehms Lane</u>					



B 210 1

70 12543

BALTIMORE CITY HEALTH DEPARTMENT

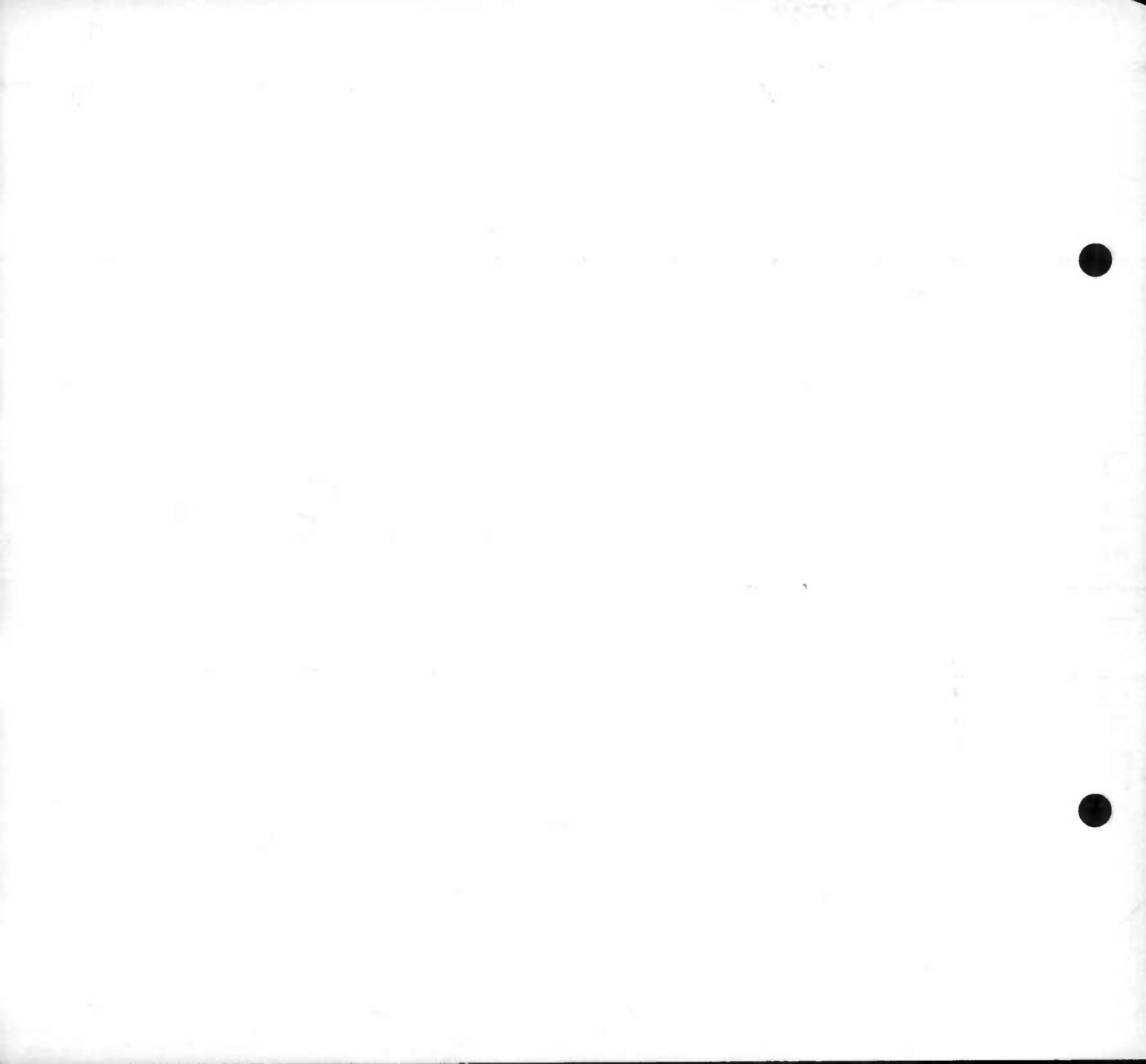
CERTIFICATE OF DEATH

REG. NO. 70 12543

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO. <u>Backof</u>		2. DATE AND HOUR OF DEATH <u>12-13-76 10AM</u>	
1. NAME OF DECEASED (Type or Print) <u>Backof, Anna M.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>602</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>Harbor View Nursing Center</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2603 East Fairmont Avenue</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-18-89</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE (In years last birthday) <u>84yrs</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Backof</u>		14. MOTHER'S MAIDEN NAME <u>Kunigunda Rein</u>	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Chart</u>
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Drugs</u> (B) <u>Arteriosclerotic Cardio Vascular</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> <u>Indefinite medical examination</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/10</u> 19 <u>70</u> to <u>12/13</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>12/13</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>John A. ...</u>		23B. DATE SIGNED <u>12-14-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>ROLENDO S. BUNOPO M.D.</u>		23D. ADDRESS <u>Harbor View Nursing Home</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>12-15-70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	24D. LOCATION (City, town, or county) <u>BALTB MD</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 28 1970</u>	25B. NAME OF REGISTRAR <u>Robert E. ...</u>	25C. FUNERAL DIRECTOR <u>CHAS. F. LUANO</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12544</u>	
70 12544				CERTIFICATE OF DEATH	
BIRTH NO. <u>70 12544</u>		1. NAME OF DECEASED (Type or Print) <u>WLADYSLAW WEGICKI</u>		2. DATE AND HOUR OF DEATH <u>12/21/70</u> <u>4:05 P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>90</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Gould Home</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2646</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>6721 Youngstown Avenue</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-II-1886</u>	9. AGE (in years last birthday) <u>84</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Beth Steel Co</u>	11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Stephen Weglicki</u>			14. MOTHER'S MAIDEN NAME <u>Janina</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Mr. William Weglicki 6733 Danville Avenue</u>		
18. <u>4/12/83 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Cachexia Cor Pulmonale Chronic Bronchitis - Depression Epilepsy</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial Infarction</u> (B) <u>Anterior wall Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Chronic Bronchitis - Depression Epilepsy</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>years</u>
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>6/19/70</u> 19 <u>70</u> to <u>12/21/70</u> that (I) ( <u>we</u> ) last saw the deceased alive on <u>12/20/70</u> 19 <u>70</u> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>we</u> ) ( <del>did</del> ) ( <u>did not</u> ) view the body after death.					
23A. SIGNATURE <u>Walter Dabrowski</u>			23B. DATE SIGNED <u>12/21/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Robert E. Fisher, M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>12-24-70</u>	24C. NAME of CEMETERY or CREMATORY <u>St. Stanislaus Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>			25A. DATE REC'D BY HEALTH DEPT. <u>DEC 28 1970</u>		
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>			25C. FUNERAL DIRECTOR ADDRESS <u>WALTER DABROWSKI 1005 DUNDALK AVENUE</u>		

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12545	
BIRTH NO. 70 12545		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Glady Annas</i>		2. DATE AND HOUR OF DEATH <i>Dec. 22, 1970</i> 3:55p M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2720</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Jewish Convalescent Home</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>4601 Pall Mall Rd</i>					
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/25/81</i>	9. AGE (In years lost birthday) <i>88</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Merchant</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Russia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>Abraham</i>		14. MOTHER'S MAIDEN NAME <i>Sarah</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>223-42-1622</i>		17. INFORMANT <i>Mrs. Irene Kitch</i>	
18. <i>4709 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial Infarction</i> (B) <i>Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Diabetes Mellitus</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Hours</i> <i>years</i> <i>years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Dec. 17, 1970</i> to <i>Dec. 22, 1970</i> , that (I) (we) last saw the deceased alive on <i>Dec. 17, 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>David I. Miller</i>		23B. DATE SIGNED <i>Dec. 23, 1970</i>		23C. PHYSICIAN'S NAME (Type) <i>David I. Miller</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/23/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Old Friends</i>	
24D. LOCATION <i>Balto</i>		24E. NAME OF REGISTRAR <i>Robert E. Taylor</i>		24F. FUNERAL DIRECTOR <i>Sylvan Lewis &amp; Son</i>	
24G. ADDRESS <i>9610 Reisterstown Rd</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 28 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>			
25C. FUNERAL DIRECTOR <i>Sylvan Lewis &amp; Son</i>		25D. ADDRESS <i>9610 Reisterstown Rd</i>			

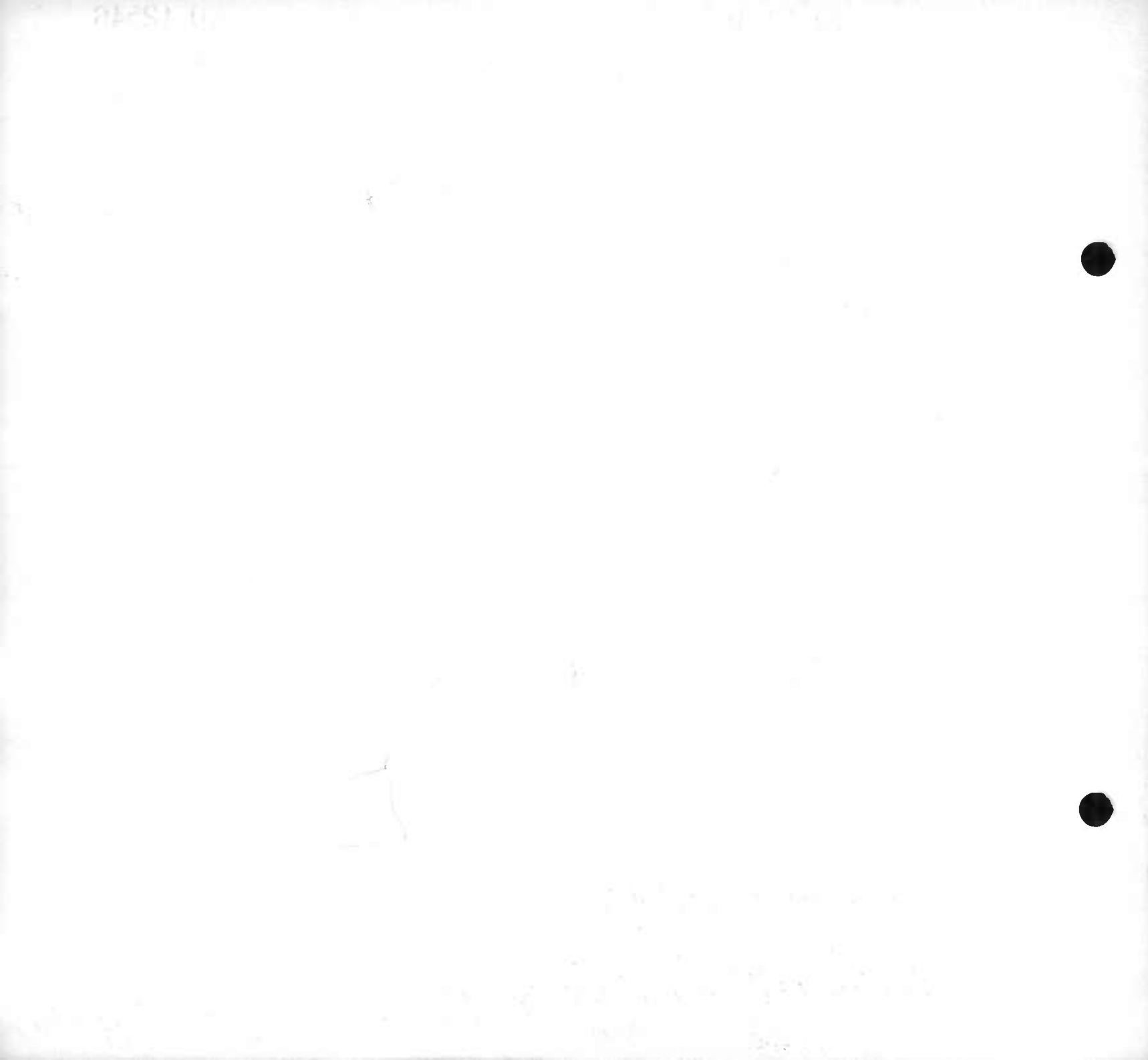
3601 Clark's La. Admitted 10/7/70.

CT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 12546	
CERTIFICATE OF DEATH				REG. NO. 70 12546	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Dolphus Hall</u>		2. DATE AND HOUR OF DEATH <u>12/19/70</u> <u>1</u> <u>905</u> <u>A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2544</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore Gen. Hosp.</u> <u>43</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>811 Glade Ct., Balt., Md. 21225</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/19/15</u>	9. AGE (in years last birthday) <u>55</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Disabled Veteran</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>?</u> (deceased)		
14. MOTHER'S MAIDEN NAME <u>?</u> (dec.)			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>?</u>		
16. SOCIAL SECURITY NO. <u>?</u>			17. INFORMANT <u>Hospital records</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(A) IMMEDIATE CAUSE <u>CHF</u> DUE TO, OR AS A CONSEQUENCE OF:					
(B) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF:					
(C) <u>Chronic Renal Failure (K-W disease)</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes mellitus</u>					
19A. DATE OF OPERATION <u>25091</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/7</u> 19 <u>70</u> to <u>12/19</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>12/19</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>James A. Kopper M.D.</u> DEGREE				23B. DATE SIGNED <u>12/19/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>James A. Kopper M.D.</u> DEGREE				23D. ADDRESS <u>SBGH</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>12/24/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 28 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Tabor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Stuart Wilson 11913</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 70 12547

BIRTH NO. 1563270 12547		1. NAME OF DECEASED (Type or Print) MOLLIE SCHWARTZ		2. DATE AND HOUR OF DEATH DECEMBER 21, 1970 10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION CHERRY'S GUEST NURSING HOME 1712 LIBERTY HTS AVE		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3712 LIBERTY HEIGHTS AVENUE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 25, 1907	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEVER WORKED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME BENJAMIN SCHWARTZ		14. MOTHER'S MAIDEN NAME MARY DESSER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR. HERBERT A. SCHWARTZ, 1013 AMERICAN BLDG.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Thrombosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Diabetes		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Low	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1970 to Dec 1970 that (I) (we) lost saw the deceased alive on 11/15/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph Shear		23B. DATE SIGNED 12/21/70		23C. PHYSICIAN'S NAME (Type) JOSEPH SHEAR	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-22-70		24C. NAME OF CEMETERY or CREMATORY BETH TFILOH	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. DEC 28 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25D. ADDRESS		25E. ADDRESS	

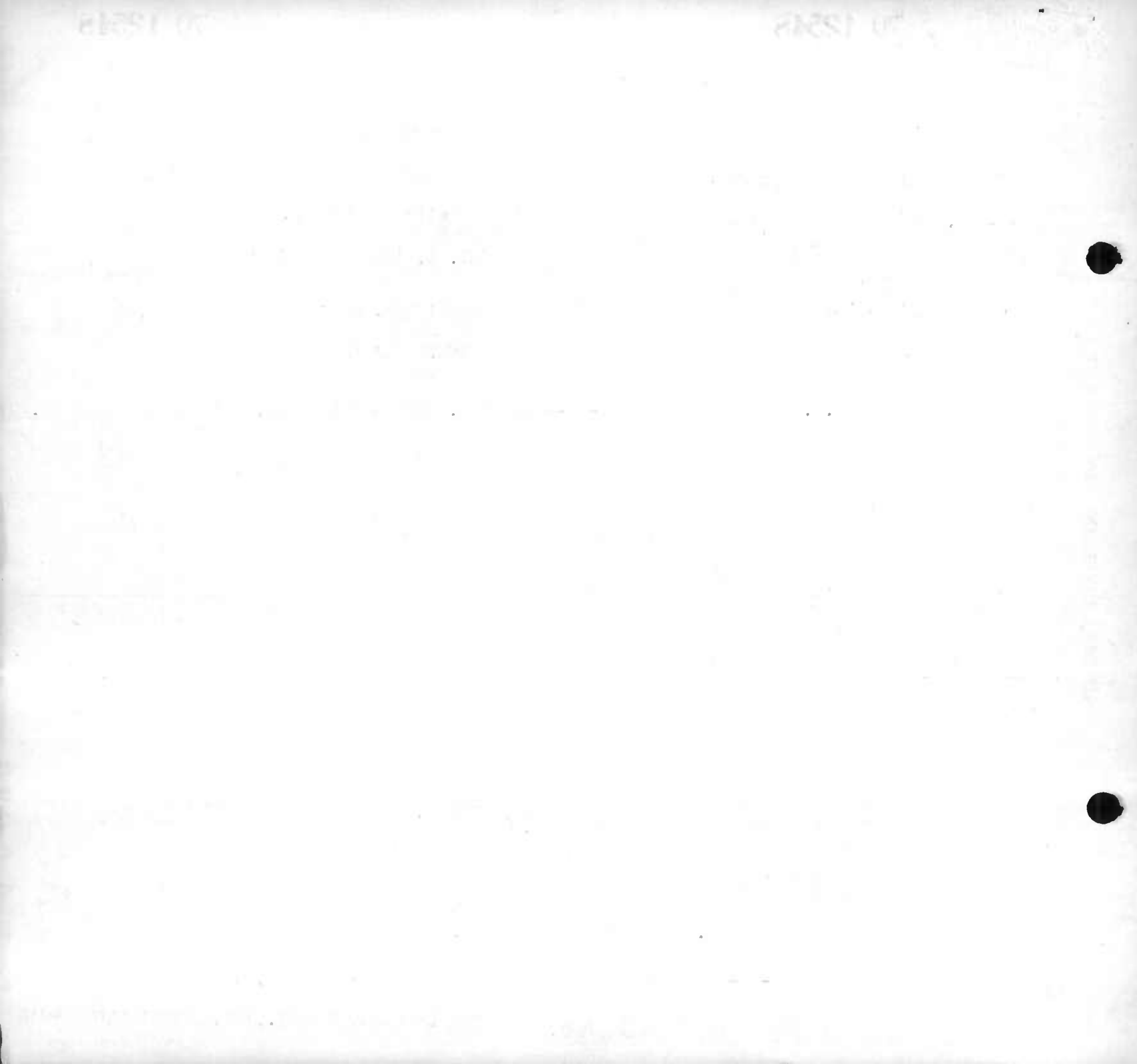
NO other Address obtainable

51251 07

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						REG. NO. <u>70 12548</u>	
70 12548 CERTIFICATE OF DEATH							
BIRTH NO.		1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
		SAMUEL WOLFOVITZ				12/22/70 7:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  6119 WESTERN RUN DRIVE 00				A. STATE		B. COUNTY	
				MARYLAND		2740	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				6119 WESTERN RUN DRIVE #21209			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		OCT. 1, 1909		61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
PHARMACIST		DRUG STORE		BALTIMORE, MARYLAND		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
SAUL WOLFOVITZ				MINNIE SLAVIN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
YES		W.W. II ARMY		218-32-3363		MRS. BERTHA WOLFOVITZ, 6119 WESTERN RUN DR. #9	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  450X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  Pulmonary Embolus  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  15 yrs			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
O							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>Dec 4</u> 19 <u>58</u> to <u>Dec 22</u> 19 <u>70</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>Nov 24</u> 19 <u>70</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
<u>Stanley R. Steinbach M.D.</u>				12-22-70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
STANLEY R. STEINBACH				11 SLADE AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		12-23-70		MOSES MONTIFIORE		BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 28 1970		Robert E. Fisher, M.D.		SOL LEVINSON & BROS.		6010 REISTERSTOWN ROAD	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## CERTIFICATE OF DEATH

REG. NO.

70 12549

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ANNA EDLAVITCH

2. DATE AND HOUR OF DEATH

DECEMBER 20, 1970

9:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)LAKE DRIVE NURSING HOME  
2401 EUTAW PLACE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

2401 EUTAW PLACE

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY

NONE

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

HERMAN S. EDLAVITCH

14. MOTHER'S MAIDEN NAME

SARAH FISHER

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

214-56-4742

17. INFORMANT

COMMUNITY HEALTH FACILITIES

ADDRESS

1400 JOHN STREET, BALTO., MD. 21217

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

old CVA + Chronic Bronchitis

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-20 1968 to 12-20 1970,  
that (I) (we) last saw the deceased alive on Dec 17 1970 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S  
NAME (Type)MARCELINO E. ALBUERNE  
MAURICE ALBURNEAttending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

23D. ADDRESS

7935 PIPERS PATH, GLEN BURNIE, MD.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

12-22-70

24C. NAME OF CEMETERY or CREMATORY

MIKRO KODESH

24D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

DEC 28 1970

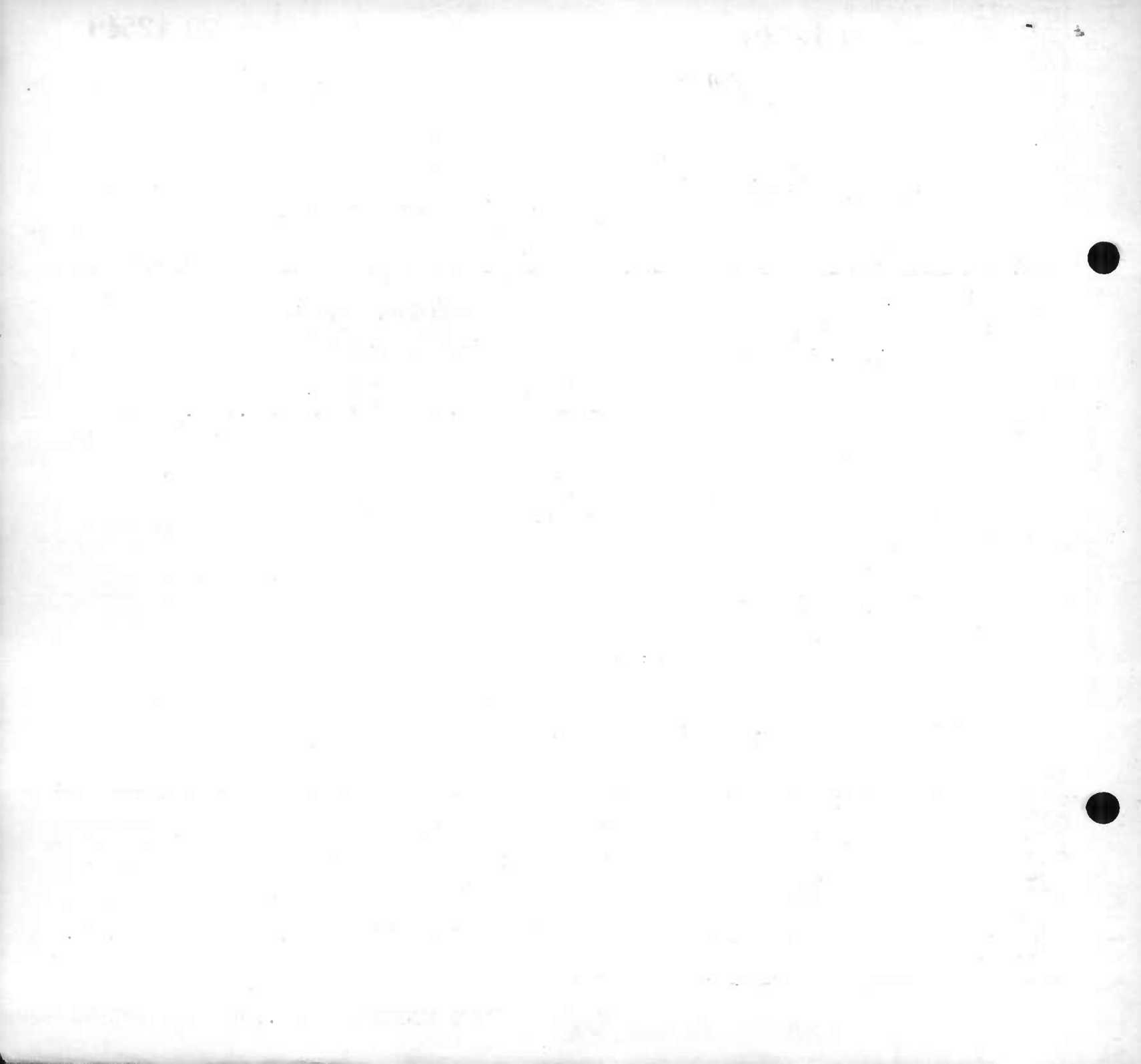
25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12550		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12550	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Susie Phoebe Grubb</u>		2. DATE AND HOUR OF DEATH <u>12/21/70</u> <u>9:10 p.m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Cecil</u>		5. CITY OR TOWN <u>North East</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		E. STREET AND NUMBER <u>Route # 1 North East, Maryland</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/18/92 96</u>	9. AGE (in years last birthday) <u>78</u> <u>74</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Franklin D. Cornett</u>		14. MOTHER'S MAIDEN NAME <u>Unknown Arlene Pugh</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>820-00-0854</u> <u>214-34-4956</u>		17. INFORMANT <u>BCH: Records</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>	
18. <u>410.1 I</u> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial infarction</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>19 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial infarction</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>CVA</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF: <u>5 years</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/21</u> 19 <u>70</u> to <u>12/21</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>12/21</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>H. S. Goldberg, M.D.</u>		23B. DATE SIGNED <u>12/21/70</u>		23C. PHYSICIAN'S NAME (Type) <u>H. S. Goldberg, M.D.</u>	
23D. ADDRESS <u>Baltimore City Hospitals</u>		23E. NAME OF CEMETERY OR CREMATORY <u>Friends Cemetery</u>		23F. LOCATION (City, town, or county) (State) <u>Calvert Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>12/24/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Calvert</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 28 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Grant Funeral Home</u> ADDRESS <u>North East, Md.</u>	



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BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 70 12551											
BIRTH NO. 12551				1. NAME OF DECEASED (Type or Print) Harold Paschall Keller				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.											
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) rear of 1800 W. Mulberry St.				3. DATE PRONOUNCED DEAD Month Day Year Hour 12 14 70 12:30 p.m.				5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Washington, D.C. B. COUNTY V-48											
6. SEX male		7. RACE white		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
9. DATE OF BIRTH 3-23-22		10. AGE (In years last birthday) 48		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY?		E. STREET AND NUMBER 5707 Ridgefield Rd.											
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer				14B. KIND OF BUSINESS OR INDUSTRY				15. MOTHER'S MAIDEN NAME Lillian Evans											
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes				17. SOCIAL SECURITY NO. NW II		18. INFORMANT Mrs. Lillian Keller		ADDRESS (e.)											
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty alteration of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
20A. DATE OF OPERATION 3-27-70				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes											
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?											
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) OF INJURY				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?											
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner 12/16/70				24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12-22-70				24C. NAME OF CEMETERY or CREMATORY Gettysburg National				24D. LOCATION (City, town, or county) (State) Gettysburg Pa.			
25A. DATE REC'D BY HEALTH DEPT. DEC 28 1970				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.				25C. FUNERAL DIRECTOR P. A. Pumphrey, P.A.				ADDRESS Bethesda, Md.							

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BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12552

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Donald Lee Phillips Sr.

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION

44 Union Memorial 1-6-71

3. DATE PRONOUNCED DEAD Month Day Year Hour M.  
12 26 70 5:00 P M.5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE Maryland B. COUNTY 2749

6. SEX

male

7. RACE

white

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

2-23-1927

10. AGE (In years lost birthday)

43

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

1643 Heathfield Rd.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Levin Phillips

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ret'd

14B. KIND OF BUSINESS OR INDUSTRY

Co. Surburban Chev.

15. MOTHER'S MAIDEN NAME

Crystal Boehrer Boehrer

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

17. SOCIAL SECURITY NO.

220-20-1097

18. INFORMANT

Mrs. Donald L. Phillips Same

ADDRESS

19.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)  
yes22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ - Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

Deputy Chief Medical Examiner

DATE SIGNED

12/26/70

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-30-1970

24C. NAME OF CEMETERY or CREMATORY

Woodlawn Cemetery

24D. LOCATION (City, town, or county)

Woodlawn Balto. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 28 1970

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

H. W. Jenkins &amp; Sons Co.

ADDRESS

4905 York Road Balto., Md.

B.C. #D-14826 and V.S. 153

1-6-71

M.H.

FUNERAL DIRECTOR: IMPORTANT

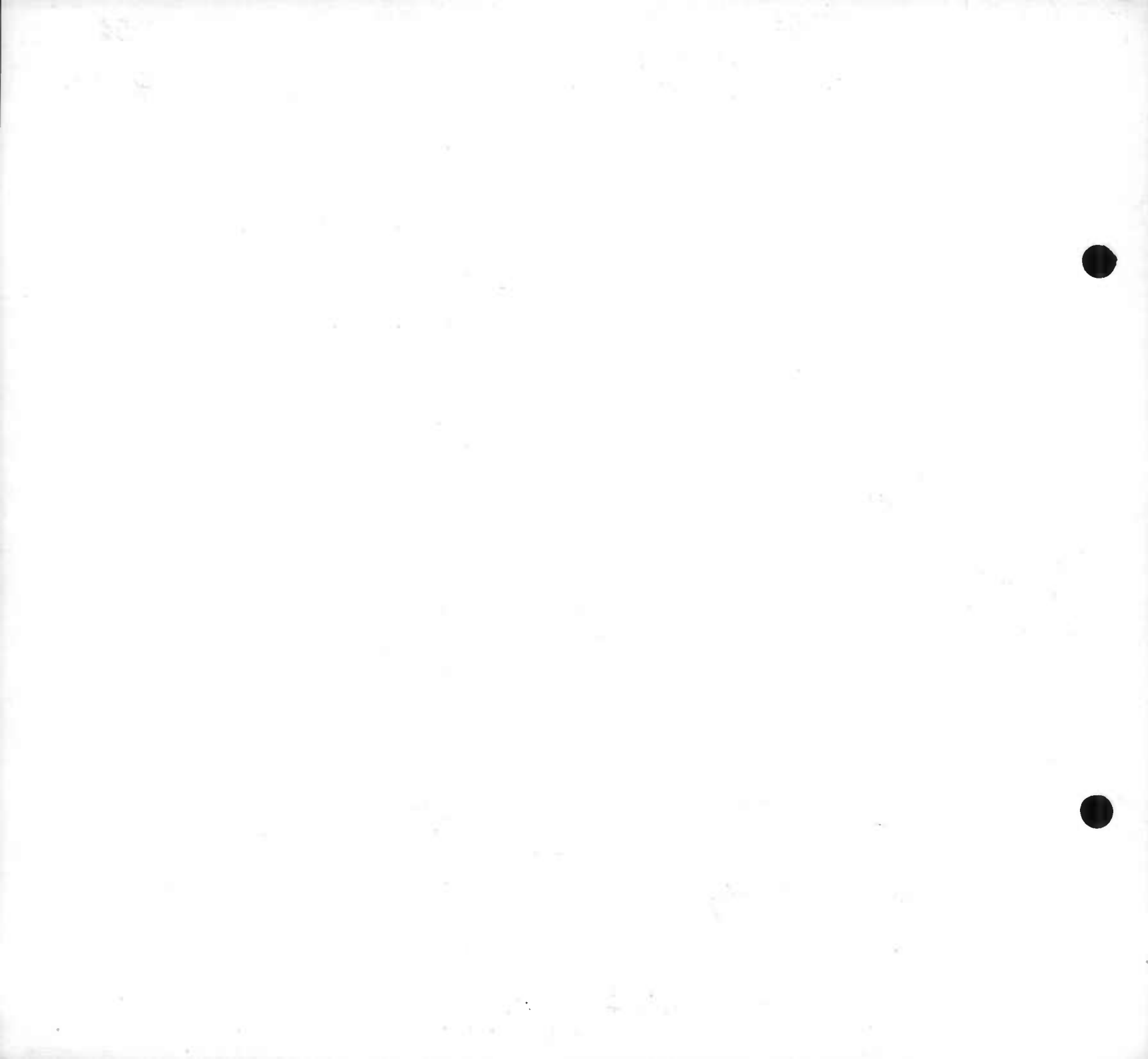
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12553</u>	
BIRTH NO. <u>70 12553</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Randall</u> <u>IDA STEUART</u>		2. DATE AND HOUR OF DEATH <u>12-27-70</u> <u>5:10 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 THE JOHNS HOPKINS HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1201</u>			
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>3805 FENCHURCH RD.</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-04-97</u>	9. AGE (In years lost birthday) <u>73</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>SAMUEL RANDALL</u>			
14. MOTHER'S MAIDEN NAME <u>ELIZABETH SISSON</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Gordon Steuart</u>		ADDRESS <u>Same</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac Failure</u> (B) <u>Probable Myocardial Infarct</u> (C) <u>Atherosclerotic C.V. Disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u> <u>5 hrs</u> <u>Many years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Abdominal Aortic Aneurysm - Ruptured</u>					
19A. DATE OF OPERATION <u>12/16/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Abd Aortic Aneurysm</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (If) (this hospital) attended the deceased from <u>12/13</u> 19 <u>70</u> to <u>12/26</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>12/26</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Vincent L Gott</u>		23B. DATE SIGNED <u>12/26/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Vincent L Gott</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-29-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>	
24D. LOCATION <u>Pikesville</u>		24E. ADDRESS <u>Md.</u>		24F. STATE <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 28 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins Sons Co.</u>	
25D. ADDRESS <u>4905 York Rd.</u>		25E. CITY <u>Baltimore, Md.</u>		25F. ZIP CODE <u>21212</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burning; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

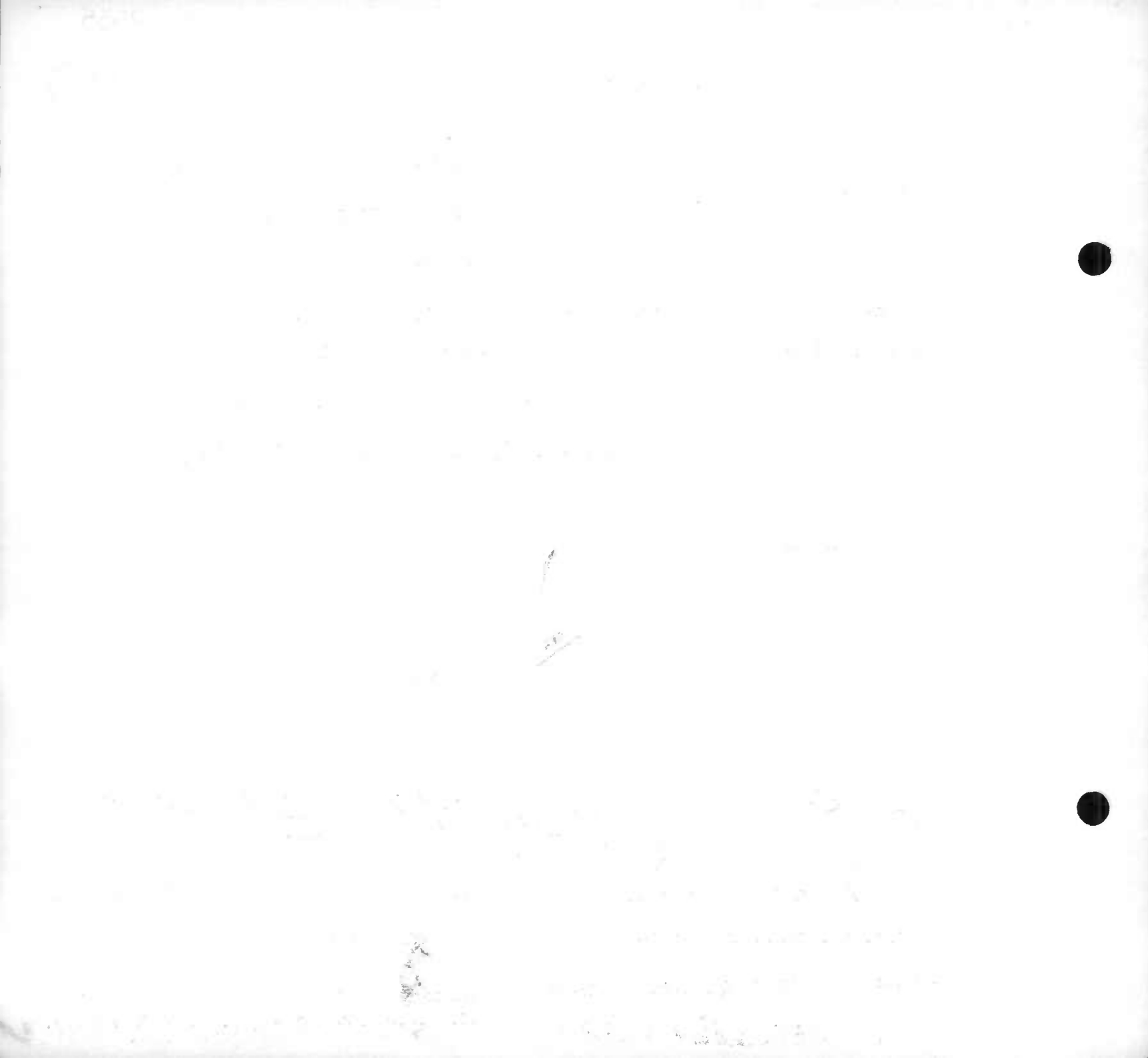
70 12554		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12554	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>LIVSEY MARY A PEYTON</i>			2. DATE AND HOUR OF DEATH <i>12/26/70 1:45 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Gould Convalesarium</i>			A. STATE <i>Md.</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>212 W. Madison St.</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-16-1893</i>	9. AGE (In years last birthday) <i>77</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Balto., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Francis B. Livesey</i>			14. MOTHER'S MAIDEN NAME <i>Eleanor Rites</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>216-01-1343A</i>		17. INFORMANT <i>Mrs. Tabatha Stone</i>
			ADDRESS <i>Same</i>		
18. <i>436.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, pneumonia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Recurrent Cerebrovascular Accident</i> (B) <i>Cerebrovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Cerebrovascular Stroke</i> <i>Chronic Brain Ischemia</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4-6 hrs.</i>		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>12/23/70</i> 19 <i>70</i> to <i>12/26/70</i> 19 <i>70</i> that (I) ( <del>we</del> ) last saw the deceased alive on <i>12/26/70</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>Albert O. Bradley</i>			23B. DATE SIGNED <i>12/26/70</i>		
23C. PHYSICIAN'S NAME (Type) <i>Dr. Albert Bradley</i>			23D. ADDRESS <i>4900 Belair Road</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-29-70</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. View Cemetery</i>	
24D. LOCATION <i>West Friendship, Md.</i>		24E. NAME of REGISTRAR <i>Robert E. Farley, M.D.</i>		24F. FUNERAL DIRECTOR <i>H.W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 28 1970</i>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 12555		REG. NO. 70 12555	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Margaret D. Jeffries				2. DATE AND HOUR OF DEATH 12-24-70 8:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2759			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1406 Northgate Rd.				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1406 Northgate Rd.			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-14-1893	9. AGE (in years last birthday) 77	10. Under 1 Yr. Months Days If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John L. Diehl				14. MOTHER'S MAIDEN NAME Cathering Carter			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-01-2001		17. INFORMANT B William S. Jeffries		ADDRESS Same	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) MASSIVE MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 5/8/70 19 to 12/24/70 19 that (1) (we) last saw the deceased alive on 12/11/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE W. M. Smith M.D.				23B. DATE SIGNED 12/24/70		23C. PHYSICIAN'S NAME (Type) Dr. W. Meridith Smith	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12-28-70		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	
25A. DATE REC'D BY HEALTH DEPT. DEC 28 1970				25B. NAME OF REGISTRAR Robert E. Taber, M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212	



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BALTIMORE CITY HEALTH DEPARTMENT

70 12556

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 12556

BIRTH NO.

1. NAME OF DECEASED (Type or Print) (ELLA) Ellen Mae Marriott		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 12 21 70 6:40 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4800 Alhambra Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 21 70 6:40 p.m.	
6. SEX female		7. RACE colored	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2710	
9. DATE OF BIRTH November 23, 1896		10. AGE (in years last birthday) 74 70	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Thomas		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Elizabeth Nelson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 213-14-2933		18. INFORMANT ADDRESS Mrs. Virginia Terry 4800 Alhambra Ave.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		DATE SIGNED 12/21/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-28-70	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 28 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Mary-Elizabeth Law		ADDRESS 802 Madison Ave.	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12557		BALTIMORE CITY HEALTH DEPARTMENT		70 12557	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
JOHN MITCHELL		12-28-1970		12-20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
		Maryland		1605	
46 Lutheran Hospital		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		1505 BRADDOCK AVE.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. AGE (In years last birthday)
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10-22-97	73	73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John Mitchell		Sallie Parker		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No				Samuel Mitchell	
				CHART 332 Allandale St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 10-21-1970 to 12-28-1970 and that (I) (we) lost saw the deceased alive on 12-27-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
M.R. Grace		12-28-1970			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
MANDON H. RUSTON GRACE		Lutheran Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12-31-70		Arbutus Memorial Park	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 28 1970		Robert E. Jarboe, R.D.		Mary-Elizabeth Law	
				802 Madison Ave.	

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70 12558 BALTIMORE CITY HEALTH DEPARTMENT MEDICAL EXAMINER'S CERTIFICATE OF DEATH 70 12558

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) DAVID N. MC DUFFIE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year December 24, 1970 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1930 East 30th St.		3. DATE PRONOUNCED DEAD Month Day Year Hour December 24, 1970 9:20 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 906	
9. DATE OF BIRTH 1-29-31		10. AGE (In years last birthday) 38	
11. BIRTHPLACE (State or foreign country) Southern Pines, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		15. MOTHER'S MAIDEN NAME Annie Craddie	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes #2 58/24 Mar 61		17. SOCIAL SECURITY NO. 213-28-2743	
18. INFORMANT 1930 E. 30th St. 21216 Mrs. Annie C. McDuffie		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED December 24, 1970			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-29-70	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 28 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Marshall W. Jones, Jr.		25D. ADDRESS 1735 Harford Ave. 21213	

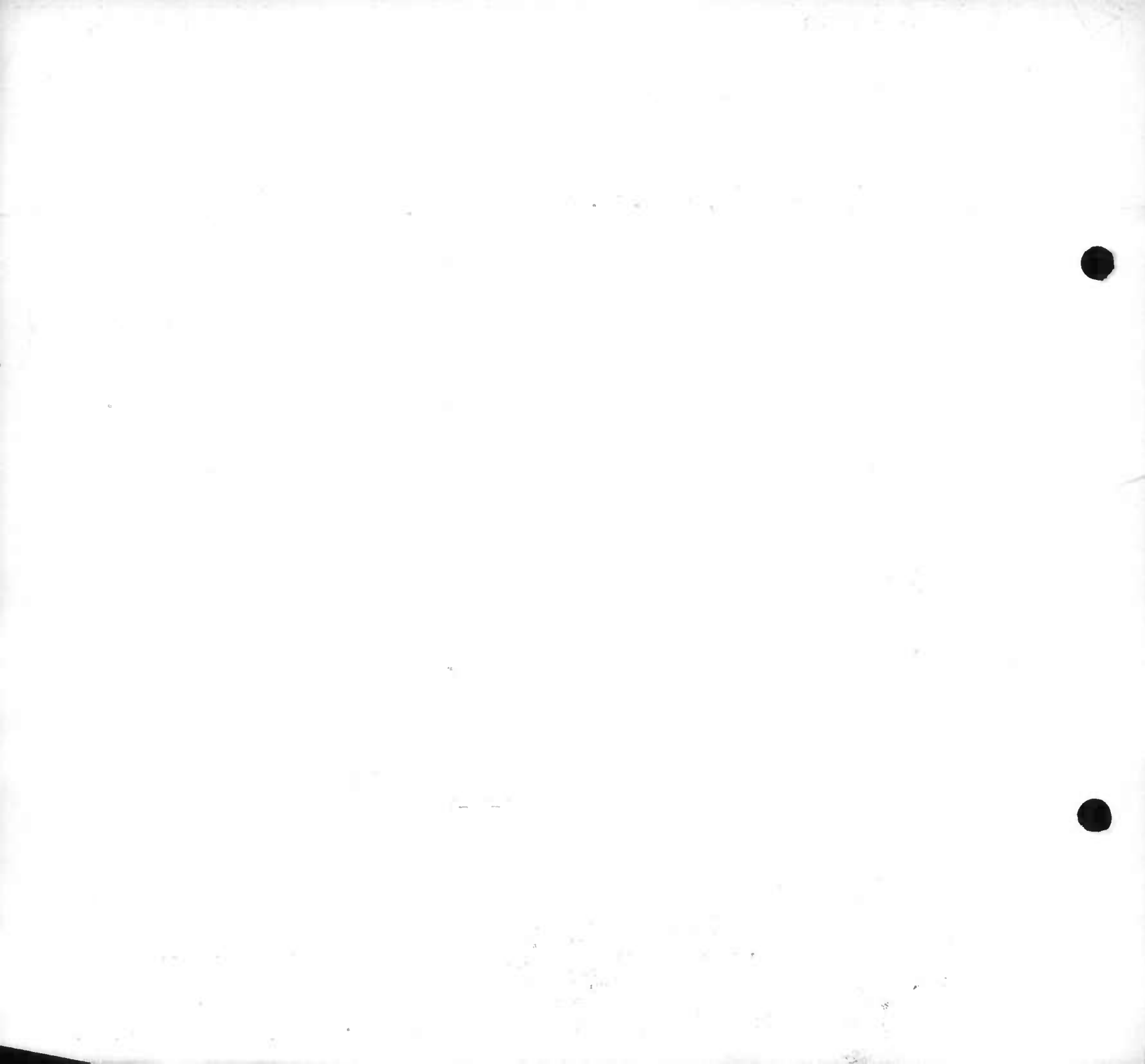
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12559	
70 12559				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>PETE KEFALAS</b>		2. DATE AND HOUR OF DEATH <b>12/17/70</b> <b>1:05 P</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTO. CITY HOSPITALS</b> <b>4940 Eastern Avenue, Balto. Md. 21224</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>730 S. Oldham Street</b>		<b>21224</b>
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-8-08</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Shoe Repair</b>		11. BIRTHPLACE (State or foreign country) <b>GREECE</b>	
12. CITIZEN OF WHAT COUNTRY <b>Greece</b>		13. FATHER'S NAME <b>MICHAEL</b>		14. MOTHER'S MAIDEN NAME <b>SEVASTI</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-36-6386</b>		17. INFORMANT <b>BCH Records, 4940 Eastern Ave Balto. Md 21224</b>	
18. <b>1529 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>RESPIRATORY + CARD. AC</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. <b>ARREST</b>			CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Carcinomatosis ? PANCREAS</b>					
19A. DATE OF OPERATION <b>12/1/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intermittent Jaundice</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-15-70</b> 19 <b>70</b> to <b>12/17</b> 19 <b>70</b> and that (I) (we) lost saw the deceased alive on <b>12/17</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ivens LaFlare</b>				23B. DATE SIGNED <b>12/17/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ivens LaFlare, MD</b>				23D. ADDRESS <b>4940 Eastern Avenue, Balto. Md., 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-21-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery, Baltimore, Md.</b>	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, R.D.</b>		25C. FUNERAL DIRECTOR <b>Nicholas T. Matthews</b> <b>3021 Eastern Ave., Baltimore, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12560		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 12560	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Beckmann Edna M.</i>			
2. DATE AND HOUR OF DEATH <i>12/23/70</i> <i>150P</i> M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>BALTIMORE</i> C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				5. SEX <i>F</i> 6. RACE <i>W</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <i>12-2/95</i> 9. AGE (In years lost birthday) <i>75</i> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.				10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Packer (ret.)</i> 10B. KIND OF BUSINESS OR INDUSTRY <i>Drug + Yeater</i>			
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>John Pulley</i> 14. MOTHER'S MAIDEN NAME <i>(Unknown)</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> 16. SOCIAL SECURITY NO. <i>213-12-2255</i> 17. INFORMANT <i>Mrs. Elizabeth L. Furst (daughter)</i> ADDRESS <i>Same As #4</i>				18. <i>1977</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Metastatic Carcinoma to Liver -</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <i>Hypertension, CVA.</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12/12</i> 19 <i>70</i> to <i>12/23</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>12/23</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Morton Kruger M.D.</i> DEGREE <i>M.D.</i> 23B. DATE SIGNED <i>12/23/70</i>				23C. PHYSICIAN'S NAME (Type) <i>Morton Kruger M.D.</i> DEGREE <i>M.D.</i> 23D. ADDRESS <i>5308 N. ARCADE AVE BALTIMORE MD. 21215</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Dec. 28/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Mem. Park</i>		24D. LOCATION (City, town, or county) (State) <i>Elkridge, RFD, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 29 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>R. Singleton</i>		ADDRESS <i>Singleton Funeral Home Glen Burnie, Md.</i>	

John Parker

Parker (rev) Doug. Foster  
John P. (unknown)  
North Carolina

No ~~xxxxxxxxxxxx~~ 212-222-222 (2nd floor) 2nd floor

Barrel Dec. 20th 1860  
W. B. Smith  
E. B. Smith  
R. B. Smith  
H. B. Smith

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <u>864</u> <u>12561</u>	
BIRTH NO. <u>7070-12561</u>		2. DATE AND HOUR OF DEATH <u>12/22/70</u> <u>9 30</u> P. M.	
1. NAME OF DECEASED (Type or Print) <u>GEORGE P. KRAMER</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>HARBOR VIEW NURSING HOME</u>		C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/16/87</u> 9. AGE (In years last birthday) <u>83</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACH. OPERATOR</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>	
13. FATHER'S NAME <u>----- Kramer</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-14-9178</u>	
17. INFORMANT <u>FLORA KRAMER</u>		ADDRESS <u>811 JACKS ST</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <u>412.41</u> <u>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>A.J.C.U. Disease</u>	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Terminal Pneumonia</u>		3 days	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-1</u> 19 <u>70</u> to <u>12-22</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>12-22</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Joseph S. Blum</u>		23B. DATE SIGNED <u>12/23/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOSEPH S. BLUM</u>		23D. ADDRESS <u>1115 N. CALVERT ST.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>12/26/70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>	
25C. FUNERAL DIRECTOR <u>Walters Funeral Home</u>		ADDRESS <u>Pratt &amp; Stricker Streets 21223</u>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12562	
BIRTH NO. 70 12562		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Max A. Cohen		2. DATE AND HOUR OF DEATH Dec 24 1970 6:05 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 1101 ST PAUL STREET, APT. 1109		A. STATE MARYLAND		B. COUNTY 1101	
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1101 ST. PAUL ST. APT. 1109			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-16-1896	9. AGE (In years lost birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR		10B. KIND OF BUSINESS OR INDUSTRY REAL ESTATE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME JACOB J. KAHN		14. MOTHER'S MAIDEN NAME FANNIE BARR		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR. S. LEONARD SOLLINS, 10 LIGHT ST., ART	
18. 4-12-4-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH C.V.A. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: A.S.C.V. Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Previous C.V.A. - with parents		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hours ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Previous C.V.A. - with parents		6 mo.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/21 1970 to 12/24 1970, that (I) (we) last saw the deceased alive on 12/23 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph S. Blum M.D.		DEGREE Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/24/70	
23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM MD		23D. ADDRESS 1115 N. CALVERT ST			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-25-70		24C. NAME OF CEMETERY or CREMATORY BETH EL MEMORIAL PARK	
				24D. LOCATION (City, town, or county) (State) RANDALLSTOWN, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

1. The first part of the report is a summary of the work done during the period covered by the report.

2. The second part of the report is a detailed account of the work done during the period covered by the report.

3. The third part of the report is a summary of the work done during the period covered by the report.

4. The fourth part of the report is a summary of the work done during the period covered by the report.

5. The fifth part of the report is a summary of the work done during the period covered by the report.

6. The sixth part of the report is a summary of the work done during the period covered by the report.

7. The seventh part of the report is a summary of the work done during the period covered by the report.

8. The eighth part of the report is a summary of the work done during the period covered by the report.

9. The ninth part of the report is a summary of the work done during the period covered by the report.

10. The tenth part of the report is a summary of the work done during the period covered by the report.

11. The eleventh part of the report is a summary of the work done during the period covered by the report.

12. The twelfth part of the report is a summary of the work done during the period covered by the report.

13. The thirteenth part of the report is a summary of the work done during the period covered by the report.

14. The fourteenth part of the report is a summary of the work done during the period covered by the report.

15. The fifteenth part of the report is a summary of the work done during the period covered by the report.

16. The sixteenth part of the report is a summary of the work done during the period covered by the report.

17. The seventeenth part of the report is a summary of the work done during the period covered by the report.

18. The eighteenth part of the report is a summary of the work done during the period covered by the report.

19. The nineteenth part of the report is a summary of the work done during the period covered by the report.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 12568

BIRTH NO. <u>70 12568</u>		1. NAME OF DECEASED (Type or Print) <u>THERESA K. TOOR</u>		2. DATE AND HOUR OF DEATH <u>12/22/70</u> <u>5:55P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL OF BALTIMORE</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2720</u> C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>7012 PARK HEIGHTS AVE</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>XXXXXX</u>	9. AGE (In years last birthday) <u>74</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (State or foreign country) <u>BALTO, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>WOLF KRESS</u>			14. MOTHER'S MAIDEN NAME <u>MARY STOCKER</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>MRS. MAXINE SOLOMON, 7032 DEERFIELD RD. #21208</u>		
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cordic embolism</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>—</u> (C) DUE TO, OR AS A CONSEQUENCE OF: <u>—</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>—</u>					
19A. DATE OF OPERATION <u>0 26</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (this hospital) attended the deceased from <u>12/19</u> 19 <u>70</u> to <u>12/22</u> 19 <u>70</u> that (we) last saw the deceased alive on <u>12/22</u> 19 <u>70</u> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Alberto Barbado, MD</u> DEGREE				23B. DATE SIGNED <u>12/22/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>ALBERTO BARBADO, MD.</u> DEGREE				23D. ADDRESS <u>Sinai Hosp.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-24-70</u>		24C. NAME of CEMETERY or CREMATORY <u>BETH TFILOH</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farley, R.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>			

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# FUNERAL DIRECTOR: IMPORTANT

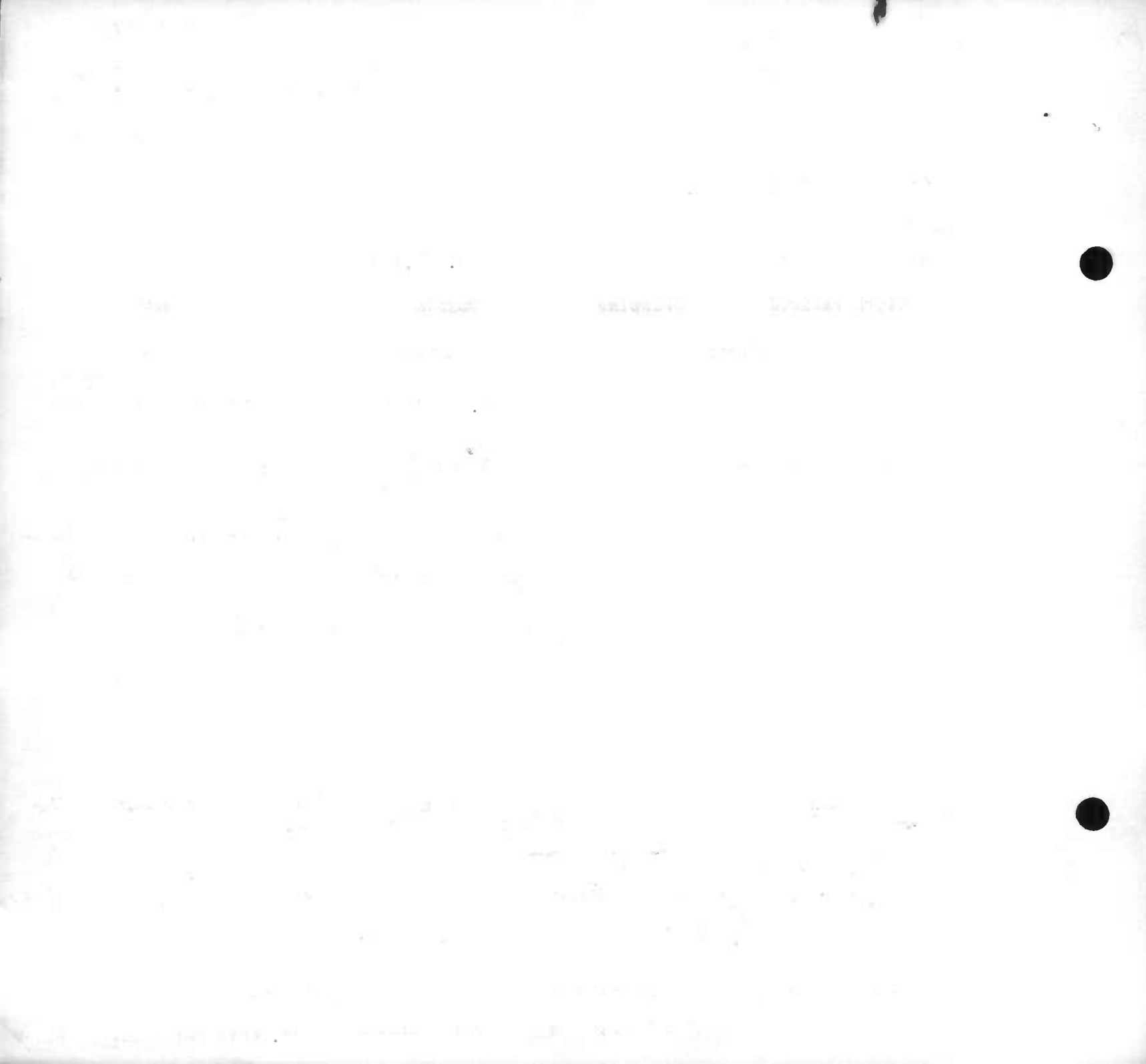
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12564	
BIRTH NO. 70 12564				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>GOLDIE SPUNGIN</b>			2. DATE AND HOUR OF DEATH <b>12-24-70 1230 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL OF BALTIMORE 42</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALT.</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3304 D CLARKS LANE</b>		
5. SEX <b>F</b> <b>Female</b>	6. RACE <b>White</b> <b>CAUC.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 25, 1885</b>	9. AGE (In years last birthday) <b>85</b>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			11. BIRTHPLACE (State or foreign country) <b>LATVIA</b>		
10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Samuel Josephson</b>			14. MOTHER'S MAIDEN NAME <b>Reva ?</b>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>215-52-2072</b>		
17. INFORMANT <b>Mr. Samuel Spungin</b>			ADDRESS <b>3304 D. Clarks Lane #15</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>severe generalized demyelitis of unknown etiology</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Diabetes Mellitus</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>severe generalized demyelitis of unknown etiology</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Diabetes Mellitus</b>		
19A. DATE OF OPERATION <b>12-29-70</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Rectal fistula</b>		
20A. AUTOPSY? (Yes or No) <input type="checkbox"/>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>10/29/70</b> 19 to <b>12/24/70</b> 19 that (I) (we) last saw the deceased alive on <b>12-24-70</b> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Shuman, M.D.</b>			23B. DATE SIGNED <b>12-24-70</b>		
23C. PHYSICIAN'S NAME (Type) <b>JOSEPH SHUMAN, M.D.</b>			23D. ADDRESS <b>SINAI HOSPITAL of Baltimore</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Dec. 25/70</b>		24C. NAME of CEMETERY or CREMATORY <b>Altz Chaim</b>	
24D. LOCATION (City, town, or county) (State) <b>Washington Blvd. Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher, Jr.</b>		25C. FUNERAL DIRECTOR <b>Sol Levinson &amp; Bros. 6010 Reisterstown Road</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12565</u>	
BIRTH NO. <u>70 12565</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>HERMAN ARENBERG</u>		2. DATE AND HOUR OF DEATH <u>December 24, 1970 7:41 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>42 Sinai Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, or institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2831</u>			
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>5509 Nome Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 17, 1890</u>	9. AGE (in years last birthday) <u>80</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Shipping</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Benjamin Arenberg 8435 Allenswood Road</u>	
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.]  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiogenic Shock</u> (B) <u>Massive Pulmonary Embolus</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u> (C) <u>Thrombophlebitis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 weeks</u> <u>years</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>8</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (1) (this hospital) attended the deceased from <u>12/24</u> 19 <u>70</u> to <u>12/24</u> 19 <u>70</u> and that (we) last saw the deceased alive on <u>12/24</u> 19 <u>70</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert L. Gorg M.D.</u>		23B. DATE SIGNED <u>December 28, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>Robert L. Gorg</u>	
23D. ADDRESS <u>Sinai Hospital</u>		23E. DEGREE <u>DEGREE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/25/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Hebrew Young Mens</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. 6010 Reisterstown Road</u>	
25D. ADDRESS <u>Sol Levinson &amp; Bros. 6010 Reisterstown Road</u>		25E. (City, town, or county) (State)			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 12566

REG. NO.

70 12566

1. NAME OF DECEASED (Type or Print) Vincent Ambrose DePaula		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital, Baltimore, Md.		3. DATE PRONOUNCED DEAD 12 26 70		Month	Day	Year	Hour 10:25 a
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Carroll							
6. SEX male	7. RACE white	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Hampstead		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH 11/10/15		10. AGE (In years last birthday) 54		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Victor E. DePaula		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Referee Sports					
15. MOTHER'S MAIDEN NAME Edna M. Cross		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No					
17. SOCIAL SECURITY NO.		18. INFORMANT Mr. Victor C. DePaula, Reisterstown, Md. 21136					
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		20. DATE OF OPERATION 21. AUTOPSY? (Yes or No) yes					
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? Rte. #30 S. Greenmount Church Rd.			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 10 19 70 4:17pm		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? driver of truck which struck utility pole			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Peter Lipkovic</i> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/26/70							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/30/70		24C. NAME of CEMETERY or CREMATORY Evergreen Memorial Park		24D. LOCATION (City, town, or county) (State) Finksburg, Carroll, Md. 21048	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Logan Byers, 8728 Liberty Rd. Randallstown Md. 21133			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 12567	
CERTIFICATE OF DEATH				REG. NO. 70 12567	
BIRTH NO. 70 12567		1. NAME OF DECEASED (Type or Print) <u>TR By Nanny</u>			
2. DATE AND HOUR OF DEATH <u>12/25/70 10:05 AM</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
A. STATE <u>Lake Dr. Naz Home</u>		B. COUNTY <u>2765</u>			
C. CITY OR TOWN <u>Balt. Md.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>2401 Eutaw Place</u>		5. SEX <u>F</u> 6. RACE <u>B</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>3/15/89</u>		9. AGE (In years last birthday) <u>81</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY?		10B. KIND OF BUSINESS OR INDUSTRY <u>Naz Home</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>—</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-14-8901A</u>		17. INFORMANT <u>Lake Drive Naz Home</u> ADDRESS <u>2401 Eutaw Place</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Branch pneumonia</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASCD &amp; CBS.</u>		<u>12/18/70</u>	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		<u>12/18/70 to</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>12/25/70</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-15</u> 19 <u>68</u> to <u>12-25</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>12-25</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W. Behm</u> M.D. DEGREE		23B. DATE SIGNED <u>12-25-70</u>		23C. PHYSICIAN'S NAME (Type) <u>MARCELINO P. ALBUERNE</u> M.D. DEGREE	
23D. ADDRESS <u>2935 PIPERS PATH Glen Burnie MD 21061</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>122670</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mount Calvary</u>		24D. LOCATION (City, town, or county) (Site) <u>Baltimore Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Jolley, M.D.</u>		25C. FUNERAL DIRECTOR <u>W. Behm</u> ADDRESS <u>2401 Eutaw Place</u>	

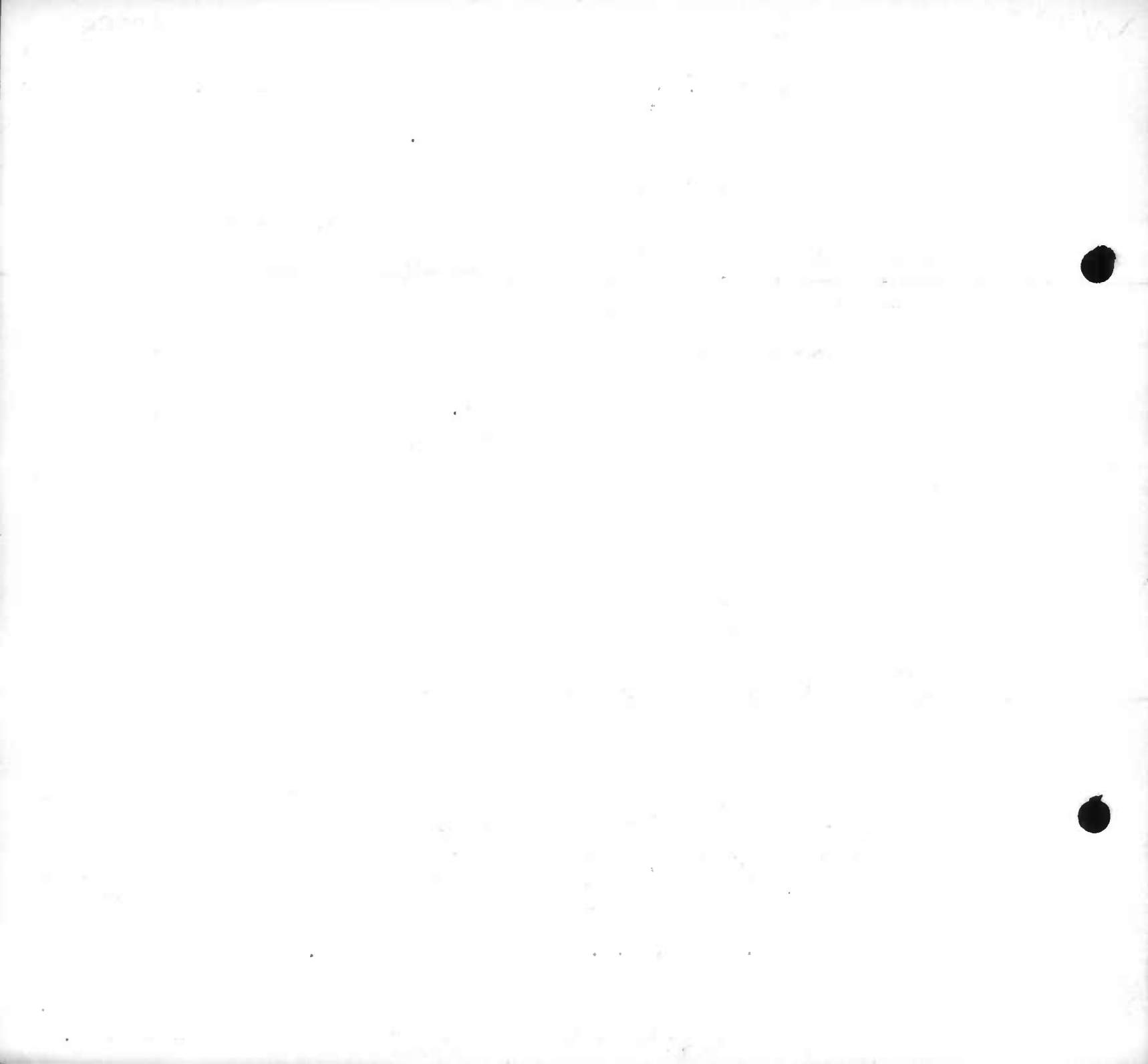
9/67. date of admission

2101 W. Gold Spring  
CT

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 12568				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12568		
CERTIFICATE OF DEATH								
1. NAME OF DECEASED (Type or Print) PEARL H. WALTMAN				2. DATE AND HOUR OF DEATH DECEMBER 23, 1970.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE Md.		B. COUNTY --		
00 2851 Chesterfield Avenue				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
				E. STREET AND NUMBER 2851 Chesterfield Avenue				
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-10-1924	9. AGE (In years last birthday) 46	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George Outten				14. MOTHER'S MAIDEN NAME Cecie Phillips				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No --			16. SOCIAL SECURITY NO. unk		17. INFORMANT Mr. Reginal Reggin			
					ADDRESS (Same)			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <i>Bronchogenic Carcinoma (Oat cell type)</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <i>None</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).								
19A. DATE OF OPERATION 8/6/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Bronchogenic Carcinoma</i>		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from July 24 1970 to December 23 1970 that (I) (we) last saw the deceased alive on December 22 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.								
23A. SIGNATURE <i>Melvin F. Polek</i>				23B. DATE SIGNED 12/24/70				
23C. PHYSICIAN'S NAME (Type) Melvin F. Polek, M.D.				23D. ADDRESS 3603 Belair Rd.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-27-70		24C. NAME OF CEMETERY OR CREMATORY First Baptist		24D. LOCATION Pogomoke City-Worcester-Md.		
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1970		25B. NAME OF REGISTRAR Robert E. Farley, Reg.		25C. FUNERAL DIRECTOR Watson Funeral Home, Pocomoke City, Md.				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>70 12569</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>70 12569</b>	
1. NAME OF DECEASED (Type or Print) <b>BEIMSCHLA, FRIEDA</b>			2. DATE AND HOUR OF DEATH <b>12-26-1970 1:15 PM</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GENERAL HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2422 N. Rolling Road</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	B. DATE OF BIRTH <b>Jan. 18, 1928</b>	9. AGE (In years last birthday) <b>42</b>	If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Ernest E. Hemmings</b>			14. MOTHER'S MAIDEN NAME <b>Rowena E. Yost</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-36-0564</b>	17. INFORMANT ADDRESS <b>Elmer H. Beimschla 2422 N. Rolling Rd. 21207</b>		
18. <b>569.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Peritonitis</b>			CAUSE OF DEATH (A) DUE TO <b>Obdominal abscess.</b> (B) DUE TO <b>Surgery of Intestinal Intub.</b> (C)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Malnutrition</b>			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>Nov. 19 1970</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intestinal Fistula</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/16/70</b> 1970 to <b>12/26</b> 1970, that (I) (we) last saw the deceased alive on <b>12/26</b> 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Chas. C. Karas</b> M.D.				23B. DATE SIGNED <b>12/26/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>KARAS</b> M.D.				23D. ADDRESS <b>M. G. Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/29/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lake View Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Essexville Carroll Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Loring Byers 8728 Liberty Road Randallstown, Maryland 21133</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

RONALD SYLVESTER DAVIS

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

ORTH ST. AGNES

St. Agnes Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

12

20

1970

12:55a

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Md.

B. COUNTY

Howard

6300

C. CITY OR TOWN

Baltimore Jessups

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

May 15, 1955

10. AGE (In years  
lost birthday)

15

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

Rt. 32 Annapolis Junction, Box 38

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME Willard

Willie Davis

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Student

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Marjorie Thomas

Marjorie Thomas

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Multiple injuries  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (if in Baltimore City, give exact location)  
INJURY OCCUR?

Thunder Hill Rd. &amp; Oakland Hill Rd.

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

12-19-70 2:14 p

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Passenger in auto accident.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-20-70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12-24-70

24C. NAME of CEMETERY or CREMATORY

Locust Cemetery

24D. LOCATION (City, town, or county) (State)

Simpsonville, Howard, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

DEC 29 1970

Robert E. Talbot, M.D.

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Robert D. Snowden

Rockville, Md.

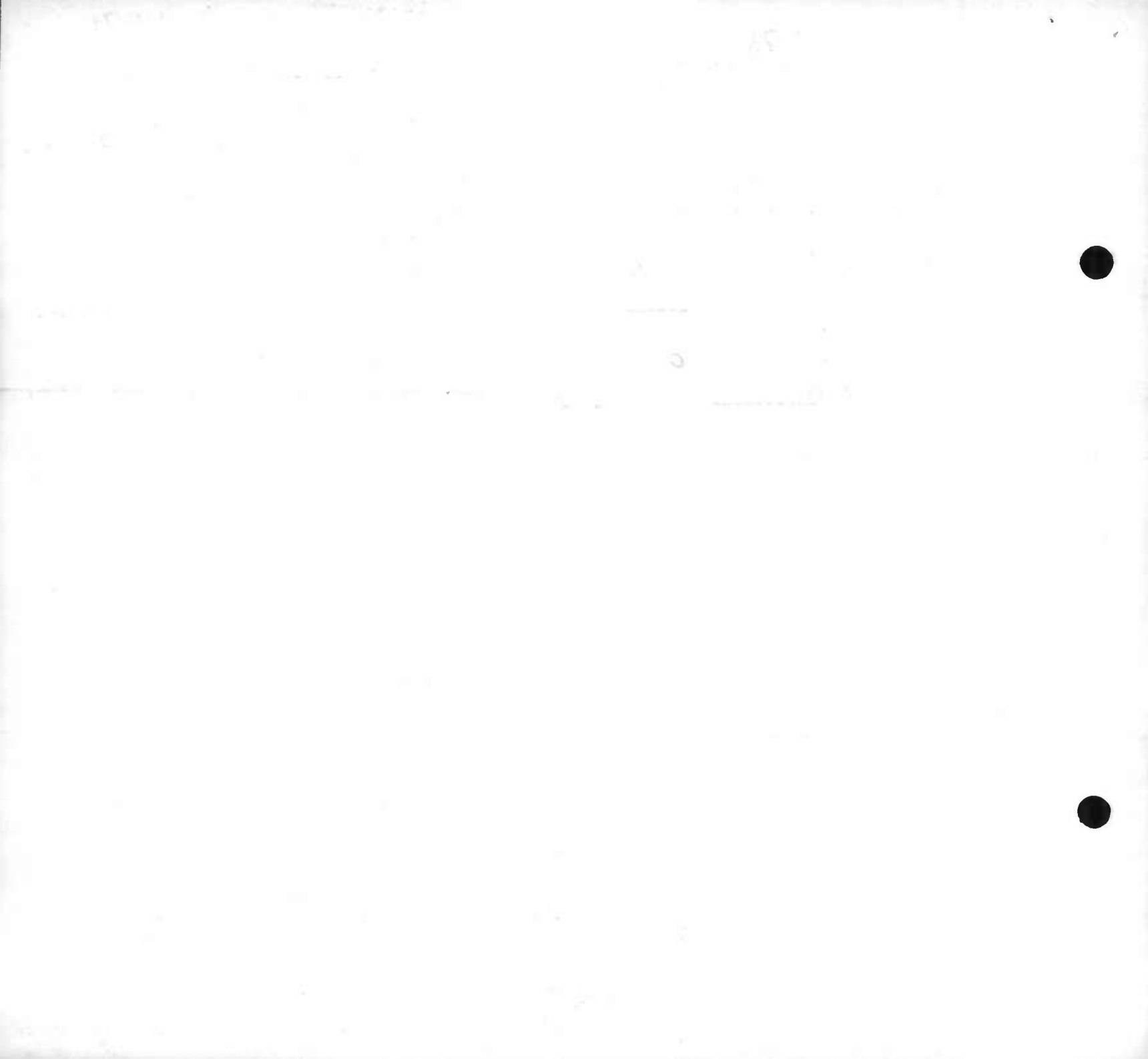
1/6/71 - Birth certificate of child, Ronald Sylvester Davis, born 5/15/1955  
in Howard County. Father: Willard Davis. Mother's Maiden Name:  
Marjory Thomas.

*Lgc.*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12571	
BIRTH NO. 70 12571				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>MARY ESTELLA STOUGH</u>			2. DATE AND HOUR OF DEATH <u>12/26/70</u> <u>3:30</u> AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIV. OF MD. HOSP.</u> <u>University of Maryland Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO.</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>5517 Gwynndale Avenue</u> <u>5517 GWYNNDALE AVE.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/10/91</u>	9. AGE (in years last birthday) <u>79</u>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. U.S.A.</u>			13. FATHER'S NAME <u>Nimrod Crooks</u> <u>NIMROD CROOKS</u>		
14. MOTHER'S MAIDEN NAME <u>Maggie Smith</u> <u>MAGGIE SMITH</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>212-10-3432</u>			17. INFORMANT ADDRESS <u>Mrs. Evelyn Greasley, 5517 Gwynndale Avenue, Baltimore, Maryland 21207</u> <u>CHART</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>733.01</u> <u>CAUSE OF DEATH</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>			(A) IMMEDIATE CAUSE <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF: <u>MYASTHENIA GRAVIS</u>		
			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>(C) OLD ANTIBIOTIC INEFFECT</u> <u>1-2 YEARS</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>12/29/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/12/70</u> 19 to <u>12/26/70</u> 19 that (I) (we) last saw the deceased alive on <u>12/26/70</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>Ira Wexler</u>			23B. DATE SIGNED <u>12/26/70</u>		
23C. PHYSICIAN'S NAME (Type) <u>IRA WEXLER</u> M.D.			23D. ADDRESS <u>University of Maryland Hospital, BALTO. MD. Baltimore, Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/29/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery Company</u>	
24D. LOCATION <u>Woodlawn, Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Loring Byers, 8728 Liberty Rd. Randallstown</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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70 12572

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

REG. NO.

70 12572

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HERBERT I. MITCHELL, JR.		December 22, 1970	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  21 Mardrew Road Baltimore, Maryland			A. STATE Maryland		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 21 Mardrew Road		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-8-1908	9. AGE (in years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician Steck		10B. KIND OF BUSINESS OR INDUSTRY Westinghouse		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Herbert Mitchell		14. MOTHER'S MAIDEN NAME Helen Coale	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-4411		17. INFORMANT Mrs. Doris C. Mitchell, 21 Mardrew Road	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac Arrest</i>		seconds	
		(B) <i>Coronary thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF:		hours	
		(C) <i>As a result of</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<i>Coronary thrombosis 1962; Angina; CHF</i>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <i>June 1962</i> to <i>12/22/1970</i> that (I) <del>last</del> last saw the deceased alive on <i>9/2/1969</i> and that in (my) <del>(my)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(did)</del> (did not) view the body after death.					
23A. SIGNATURE <i>James J. Nolan</i> James J. Nolan				23B. DATE SIGNED <i>12/24/70</i>	
23C. PHYSICIAN'S NAME (Type) James J. Nolan				23D. ADDRESS 1 Mallow Hill Road, Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-26-70		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Maryland		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1970		25B. NAME OF REGISTRAR <i>Robert E. Taylor, R.A.</i>		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	

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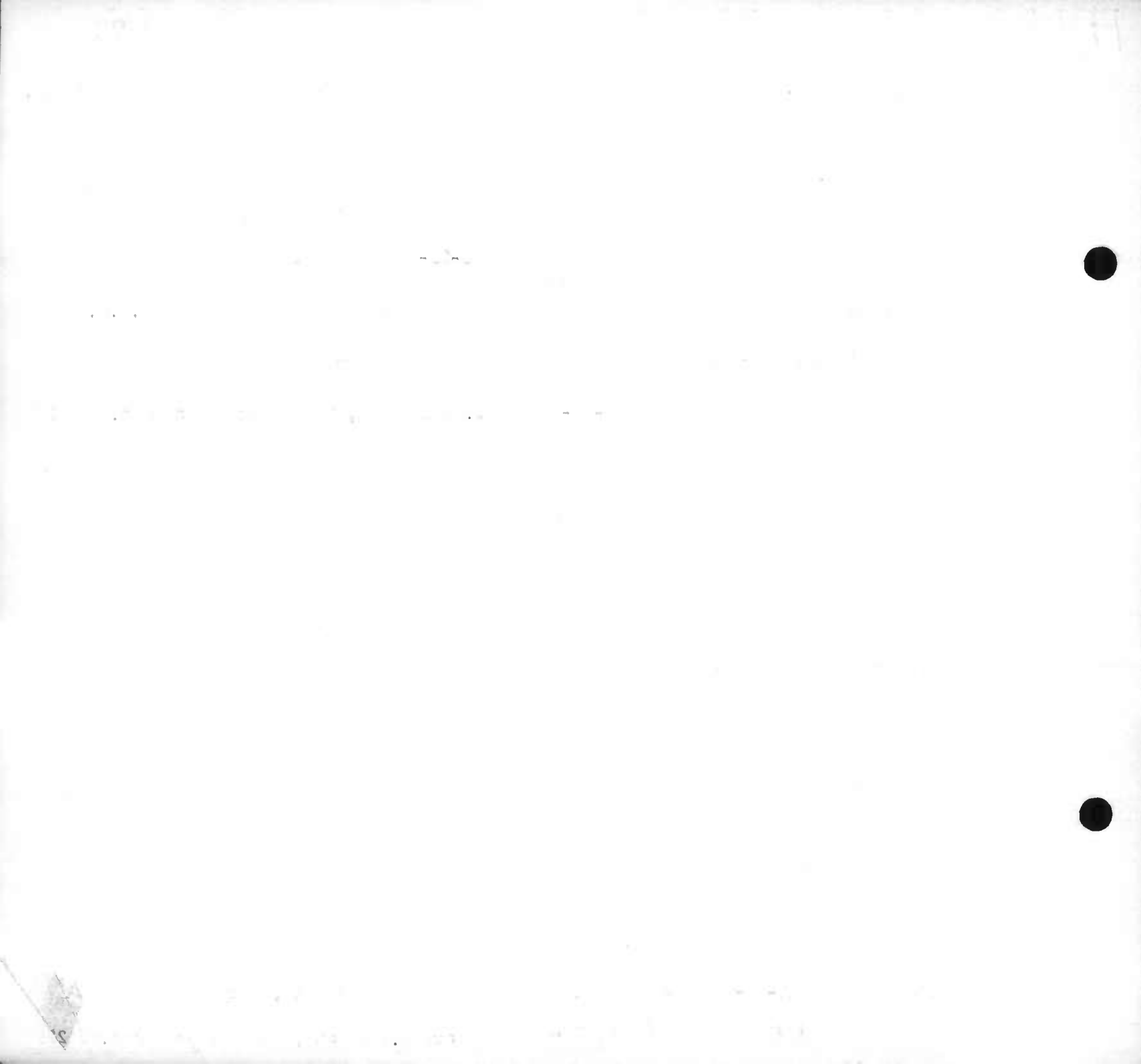
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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12578</u>	
BIRTH NO. <u>70 12578</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Hall, Louise B.</u>			2. DATE AND HOUR OF DEATH <u>12/22/70</u> <u>7:50 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 St. Agnes Hospital</u> <u>Caton &amp; Wilkens Ave</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>12572</u>		
5. SEX <u>F</u>			6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>9-25-1904</u>			9. AGE (In years, lost birthday) <u>66</u>		10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>7</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>George Block</u>		
14. MOTHER'S MAIDEN NAME <u>Katherine Rhuel</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>212-10-6028</u>			17. INFORMANT ADDRESS <u>Mr. Earl Hall, 2637 Rittenhouse Ave. 21230</u>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute myocardial infarction</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial heart disease with failure</u>		<u>months</u>
			(C) <u>Coronary heart disease</u>		<u>months</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<u>Generalized atherosclerosis</u>		<u>months</u>
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 21</u> 19 <u>70</u> to <u>Dec 22</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>Dec 21/70</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Henry Armanas M.D.</u>				23B. DATE SIGNED <u>Dec 23/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Henry Armanas, M. D.</u>				23D. ADDRESS <u>1934 Wilkens Ave. Balto, Md 21223</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<u>Burial</u>		<u>12-26-1970</u>		<u>Loudon Park Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>	



**FUNERAL DIRECTOR: IMPORTANT**

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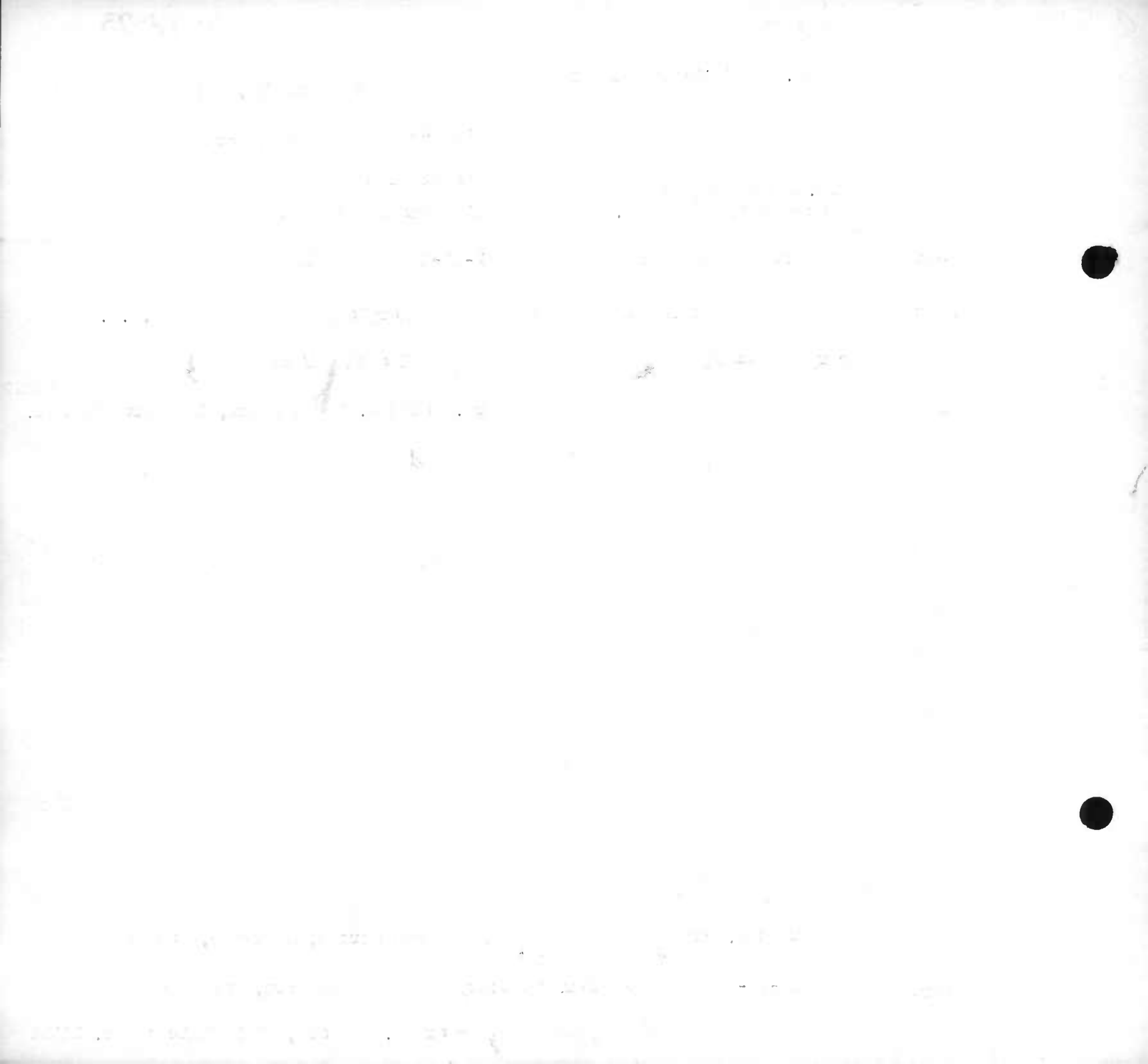
BIRTH NO. 70 12574		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 12574	
1. NAME OF DECEASED (Type or Print) SHUTT, HARSEY L. SR.				2. DATE AND HOUR OF DEATH 12/22/70 6:05 P.M. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital Wilkins & Kinross Caton Ave.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Lansdowne D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 117 Third Ave.			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1899	9. AGE (In years last birthday) 71	10. If Under 1 Yr. Months Days If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Thomas W. Shutt			14. MOTHER'S MAIDEN NAME Mary Mears				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W I			16. SOCIAL SECURITY NO. 216-07-5910		17. INFORMANT ADDRESS Mrs. Wilbur Vincent, 5548 Oakland Rd. 21227		
18. 492X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory Insufficiency ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Emphysema 8 years				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10-16-68 19 to June 19 70 that (I) (we) last saw the deceased alive on June 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Alejandro Mejia Md.				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) Alejandro Mejia Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-28-1970		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Howard H. Hubbard		25D. ADDRESS 4107 Wilkins Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH									
BIRTH NO. 70 12575		REG. NO. 70 12575							
1. NAME OF DECEASED (Type or Print) H. RAYMOND CANBY					2. DATE AND HOUR OF DEATH December 23, 1970 9:30 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  40 St. Agnes Hospital Caton & Wilkens Aves.					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Halethorpe D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1251 Francis Avenue				
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-11-1898	9. AGE (In years last birthday) 72	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Henry Canby	14. MOTHER'S MAIDEN NAME Isabel Fort
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mrs. Marie E. Householder, 1251 Francis Ave. 21227					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  410.9 I Acute coronary occlusion 2 hrs (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  Arteriosclerosis 5 yrs (B) DUE TO, OR AS A CONSEQUENCE OF: Heart disease (C) _____  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs 5 yrs				
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from Sept 1969 to Dec 23 1970 that (I) (we) last saw the deceased alive on 12/22/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Bruce B. Brumbaugh M.D. DEGREE					23B. DATE SIGNED 12/23/70			23C. PHYSICIAN'S NAME (Type) Bruce B. Brumbaugh	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 12-26-1970		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1970			25B. NAME OF REGISTRAR Robert E. Farley, M.D.			25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>70 12576</b>	
BIRTH NO. <b>70 12576</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		1. NAME OF DECEASED <b>Mehring Caroline</b>	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH <b>12-23-70 - 1:00 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>48 Maryland General Hosp. Balto, Md</b>		A. STATE <b>md.</b> B. COUNTY <b>2741</b>	
5. SEX <b>Female</b> 6. RACE <b>white</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Never married</b>		D. STREET ADDRESS (If rural, give location) <b>3303 Denton Avenue</b>	
8. DATE OF BIRTH <b>2-10-1874</b> 9. AGE (In years last birthday) <b>76</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Mehring</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Kause</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-03-6674</b>	
17. INFORMANT <b>Mabel Vogt (sister)</b>		ADDRESS <b>same</b>	
18. <b>412.4 I</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <b>Probable Septicemia</b>	
ANTECEDENT CAUSES		(B) DUE TO <b>Urinary tract infection</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <b>ASVD, Stroke?</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH <b>5-6 Wks</b>	
MEDICAL CERTIFICATION		20A. AUTOPSY? (Yes or No) <b>No</b>	
19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>7 PM</b>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-11-1970</b> to <b>12-23-1970</b> that (I) (we) last saw the deceased alive on <b>12/23</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>Whitney Houghton</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>WHITNEY HOUGHTON</b> M.D.	
23D. ADDRESS <b>MD GEN. HOSP. BALTO, MD</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>12/26/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oaklawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1970</b>	
25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Robert C. Altenburg Funeral Home Inc.</b>	
25D. ADDRESS <b>6009 Harford Rd. - Balto., Md. 21214</b>			

avcsj 07  
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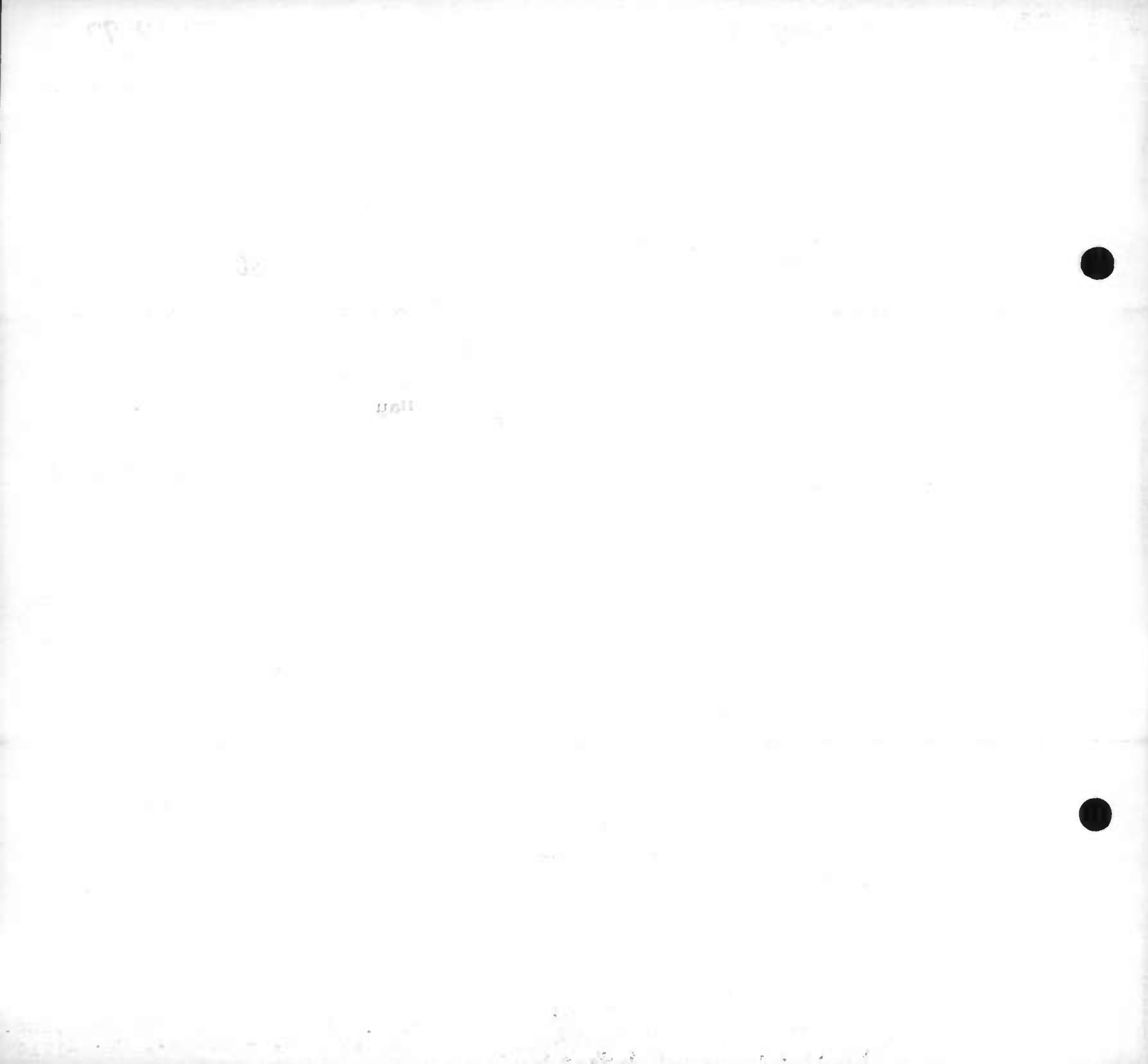
avcsj 07

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 12577

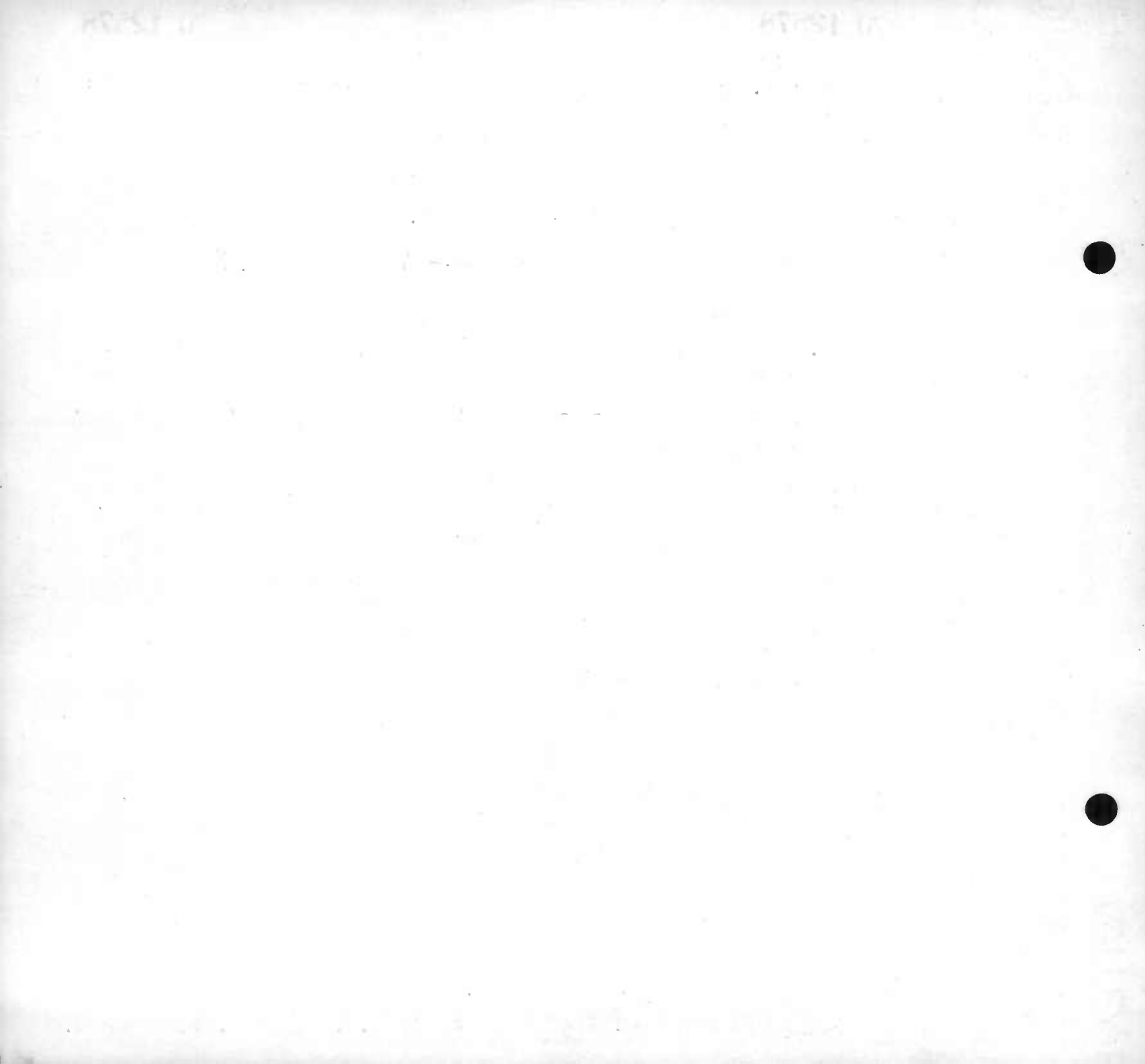
BIRTH NO. 70 12577		1. NAME OF DECEASED (Type or Print) <b>GEORGE O. HAUPT.</b>		2. DATE AND HOUR OF DEATH <b>12-23-1970 9:30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME AND HOSPITAL</b> <b>35</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2744</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3408 MARY AVE</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-16-90</b>	9. AGE (In years last birthday) <b>80</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BAKER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>	
13. FATHER'S NAME <b>OTTO HAUPT</b>			14. MOTHER'S MAIDEN NAME <b>PAULINE GOETZE</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-09-7232A</b>		17. INFORMANT (Print) <b>Haupt</b> ADDRESS <b>Anna Haupt - 3408 Mary Ave.</b>	
18. <b>I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTecedent CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>GASTRIC ULCER</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-12-1970</b> to <b>12-23-1970</b> that (I) (we) last saw the deceased alive on <b>12-23-1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Rustum. Irani</b> DEGREE <b>M.D.</b>				23B. DATE SIGNED <b>12/23/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>RUSTUM IRANI</b>				23D. ADDRESS <b>CHURCH HOME AND HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/28/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jarboe, M.D.</b>		25C. FUNERAL DIRECTOR <b>Robert C. Altenburg Funeral Home, Inc.</b> ADDRESS <b>6009 Harford Rd. - Balto., Md. 21214</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

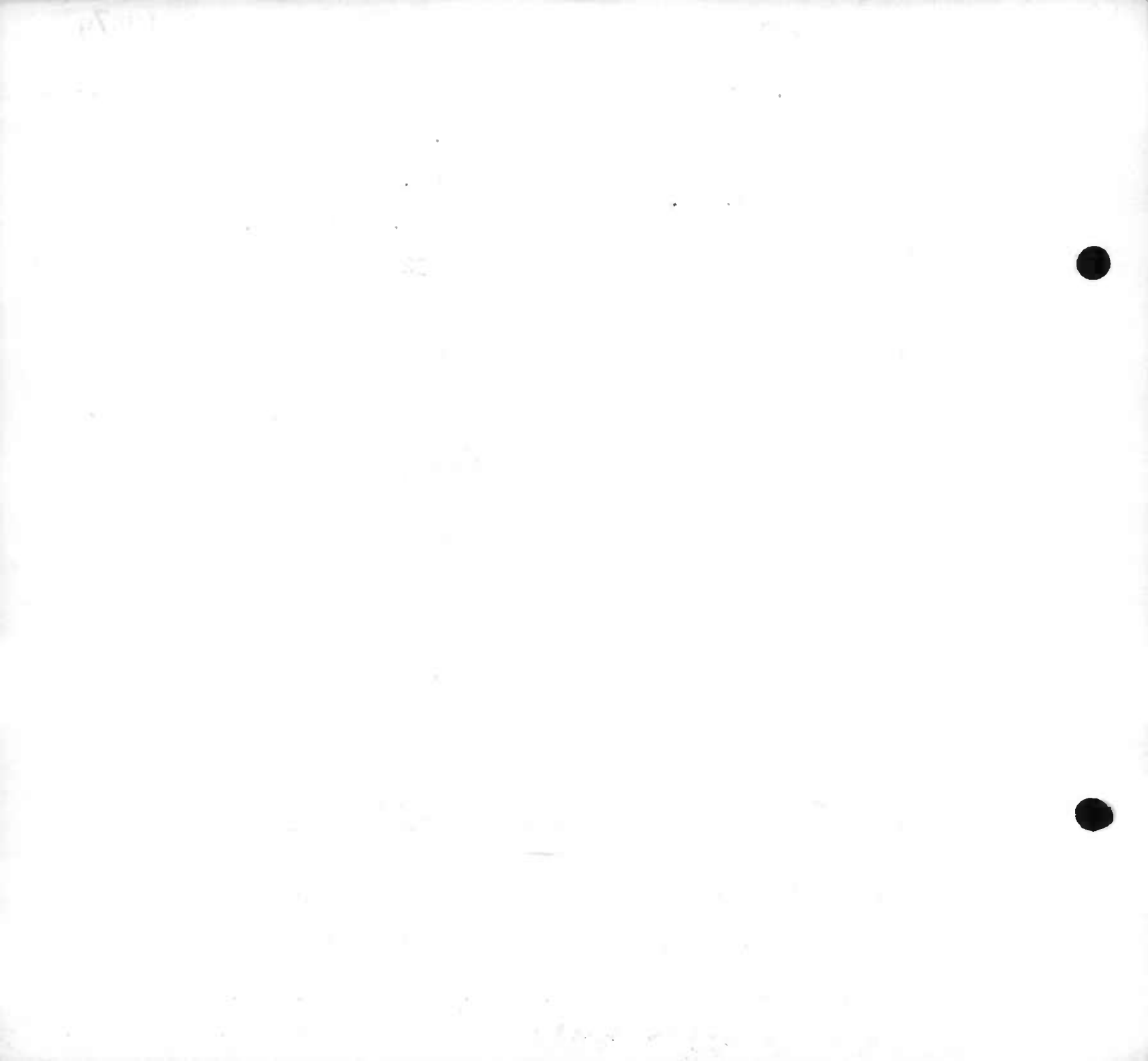
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 12578</u>	
BIRTH NO. <u>70 12578</u>		1. NAME OF DECEASED (Type or Print) <u>Dewey James D. Green</u>		2. DATE AND HOUR OF DEATH <u>12-22-70</u> <u>12:25 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Bolton Hill Nursing &amp; Convalescent Center</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> C. CITY OR TOWN <u>Baltimore</u> E. STREET AND NUMBER <u>1148 N. Calhoun Street</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/8/07</u>	9. AGE (In years lost birthday) <u>63</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Unk.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>224-20-0050</u>		17. INFORMANT <u>Julia Green 1148 N. Calhoun St.</u>	
18. <u>191X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>GLIOMA right frontal lobe</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>Diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) <u>Hypertensive C.V. disease</u>  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11/70</u> <u>11/70</u> <u>years</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>11/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Gloma / right frontal lobe / brain</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/17</u> 19 <u>70</u> to <u>12/22</u> 19 <u>70</u> , that (I) (we) lost saw the deceased alive on <u>12/22</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>ALAN H. MACHS MD</u> DEGREE				23B. DATE SIGNED <u>12/23/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>ALAN H. MACHS MD</u> DEGREE				23D. ADDRESS <u>2 E. Read St Baltimore 21202</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/28/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1970</u>			
25B. NAME OF FUNERAL DIRECTOR <u>244 E. Fairway Rd. 2</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Kelson F.H. 1348 N. Calhoun St.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 12579				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12579	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
William F. Harrison				12/27/70 1:05 <del>pm</del> <sup>am</sup>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
37 Mercy Hospital, Inc.				Md. 2003			
5. SEX M N				6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 3/28/32	
13. FATHER'S NAME William Harrison				14. MOTHER'S MAIDEN NAME Blanche Green		9. AGE (In years last birthday) 38	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) Maryland	
17. INFORMANT				12. CITIZEN OF WHAT COUNTRY?			
Blanche Jones				538 Fulton Ave.			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				PNEUMONITIS -			
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				PANCREATIC INSUFFICIENCY			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(B) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (we) (this hospital) attended the deceased from 12/23 to 12/27 1970 that (we) last saw the deceased alive on 12/27 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
D. H. Molony				12/27/70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
D. H. Molony				Mercy Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12-31-70		7.0 Audubon Circle		Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 29 1970		Robert E. Farber		Kelson P.W.		1348 N. Calhoun St.	



L 250

70 12580

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12580

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Edward Lawson</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>12 25 70 10:03 a.m.</b>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 Lutheran Hospital</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 25 70 10:03 a.m.</b>			
6. SEX <b>male</b>				7. RACE <b>colored</b>			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1509</b>			
9. DATE OF BIRTH <b>2/9/21</b>				10. AGE (In years last birthday) <b>49</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Joseph Lawson</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Brown</b>			
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Longshoreman</b>				16. KIND OF BUSINESS OR INDUSTRY			
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				18. SOCIAL SECURITY NO. <b>216-12-5336</b>			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				20. IMMEDIATE CAUSE <b>Carcinoma of stomach</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____			
21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
22A. DATE OF OPERATION				22B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22C. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22E. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>12 25 70</b>				22F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				24. AUTOPSY? (Yes or No) <b>no</b>			
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>				DATE SIGNED <b>12/26/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>12/30/70</b>			
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1970</b>				25B. NAME OF REGISTRAR <b>Robert E. Fabel, M.D.</b>			
25C. FUNERAL DIRECTOR <b>Kelson F.H.</b>				25D. ADDRESS <b>1348 N. Calhoun St.</b>			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 12581	
CERTIFICATE OF DEATH				REG. NO. 70 12581	
BIRTH NO. 70 12581					
1. NAME OF DECEASED (Type or Print) <u>ULYSSES TALLEY</u>		2. DATE AND HOUR OF DEATH <u>12/12/70</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>South Balti. Gen</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> & COUNTY <u>2543</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Balti. Gen</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Nanowet Balt.</u>		C. CITY OR TOWN <u>BALTI</u>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>4/4/02</u>		9. AGE (in years last birthday) <u>68</u>		10. UNDER 1 Yr. Months: Days 11. UNDER 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Allen Talley</u>		14. MOTHER'S MAIDEN NAME <u>Alice ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>215-03-0377</u>		17. INFORMANT <u>Annie Talley</u>	
				ADDRESS <u>2620 Puget St.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>5-7-81</u>		CAUSE OF DEATH <u>pancreatic, hepatic encephalopathy</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Liver cirrhosis, nutritional type</u>		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/12/70</u> to <u>12/24/70</u> that (I) (we) last saw the deceased alive on <u>12/23</u> 19 <u>70</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ronald H. Kirby, M.D.</u>		23B. DATE SIGNED <u>12/24/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Ronald H. Kirby, M.D.</u>	
23D. ADDRESS		23E. FUNERAL DIRECTOR <u>Kelson F.H.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/29/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Auburn Cem.</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. ADDRESS <u>1348 N. Calhoun St.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Talley, M.D.</u>		25C. ADDRESS <u>1348 N. Calhoun St.</u>	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

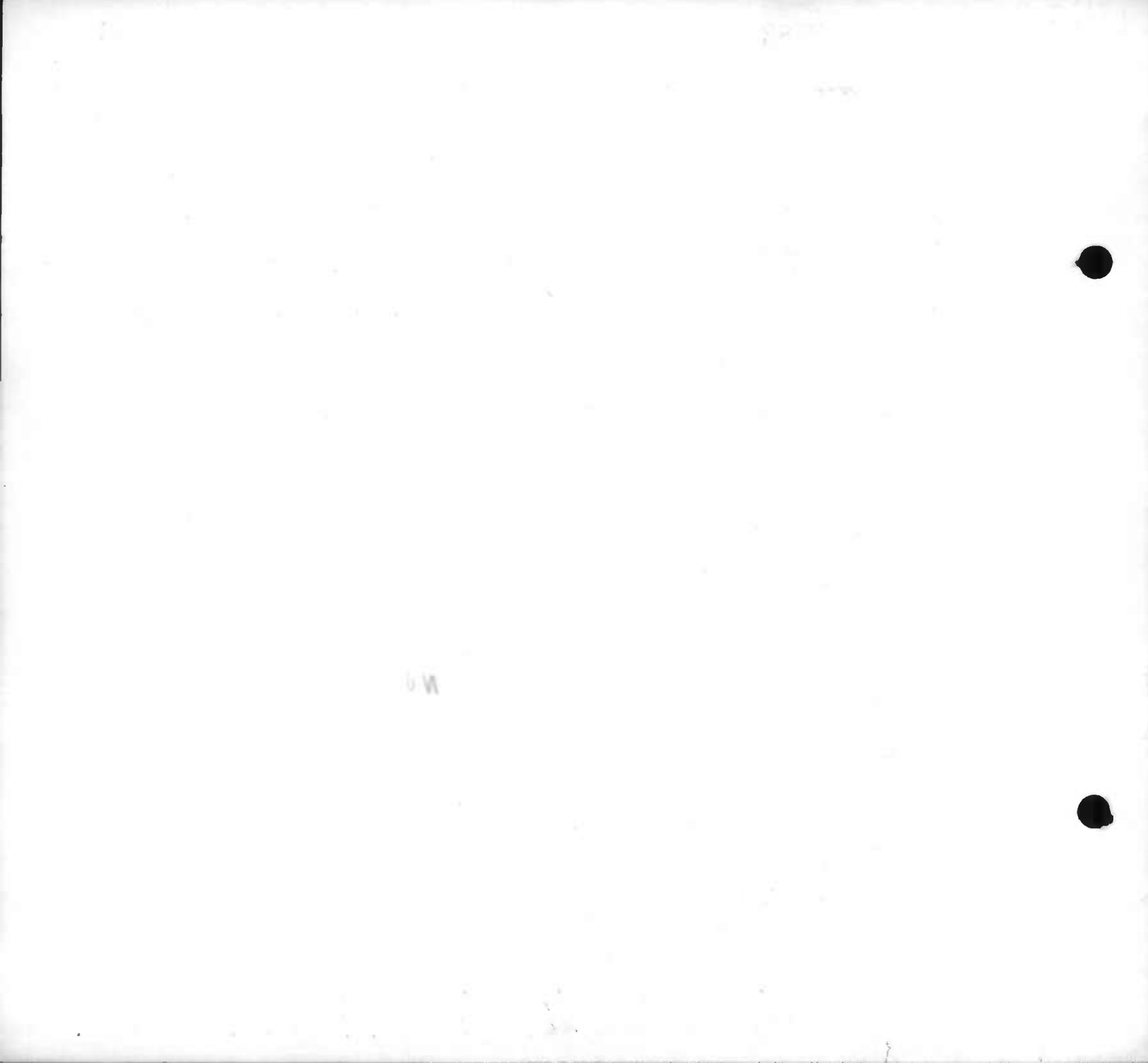
1. NAME OF DECEASED (Type or Print) Willie Steward		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 531 N. Fulton St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 22 70 12:20 P.M.	
6. SEX male		7. RACE colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1603	
9. DATE OF BIRTH April 2, 1911		10. AGE (In years last birthday) 59	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		14B. KIND OF BUSINESS OR INDUSTRY Davidson Chem.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 249-09-4842	
18. INFORMANT William A. Steward		ADDRESS P.O. 721 Conway SC	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: [Signature] M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/22/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/30/70	
24C. NAME OF CEMETERY or CREMATORY Mt. Zion Church Cem.		24D. LOCATION (City, town, or county) (State) Georgetown Co., S.C.	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Kelson R.H.		ADDRESS V.B. Bailey 1348 N. Calhoun St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>70 12588</u>				Baltimore City Health Department		REG. NO. <u>70 12588</u>	
1. NAME OF DECEASED (Type or Print) <u>JANIE B. Lyles (Robinson)</u>				2. DATE AND HOUR OF DEATH <u>12/24/70 9 PM 9:00 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital of MD</u>				A. STATE <u>MARYLAND</u> B. COUNTY <u>1501</u>			
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1522 Stricker Street</u>			
5. SEX <u>F</u>	6. RACE <u>NEG</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-21-21</u>	9. AGE (In years last birthday) <u>49</u>	If Under 1 Yr. Months: <u>—</u> Days: <u>—</u>	If Under 24 Hrs. Hours: <u>—</u> Min: <u>—</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13. FATHER'S NAME <u>UNK</u>				14. MOTHER'S MAIDEN NAME <u>UNK</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNK</u>			16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT <u>Records</u> ADDRESS		
18. <u>450X1</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE <u>ACUTE PULMONARY INFARCT</u>			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF: <u>MASSIVE PULMONARY EMBOLISM</u>			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>—</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12/18/70</u> to <u>12/24/70</u> that (I) (we) last saw the deceased alive on <u>12/24/70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>S. BASU</u>				23B. DATE SIGNED <u>DEC 29 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>S. BASU</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>Dec. 29, 1970</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Carver Mem. Park</u>	
24D. LOCATION (City, town, or county) <u>Laurel, Maryland</u>				24E. FUNERAL DIRECTOR <u>Kelson F.H.</u> ADDRESS <u>1348 N. Calhoun St.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12584	
BIRTH NO. 70 12584		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>WALTER JAMES WOODBRIDGE</u>		2. DATE AND HOUR OF DEATH <u>12-26-70</u>		10:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION <u>LUTHERAN HOSPITAL</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>1-21-71</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1510</u>		C. CITY OR TOWN <u>BALTIMORE</u>	
5. SEX <u>m</u>		6. RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>2-15-1880</u>		9. AGE (In years last birthday) <u>90</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>223-58-2741</u>		17. INFORMANT <u>Elva Blackwell</u> ADDRESS <u>4109 Barrington Rd.</u>	
18. <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <u>SS#223-58-2641</u> (A) IMMEDIATE CAUSE <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ATHEROSCLEROTIC HEART DISEASE</u> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>		19. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/13/1970</u> to <u>12/26/1970</u> , that (I) (we) last saw the deceased alive on <u>12/26/1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>S. BASU</u>		23B. DATE SIGNED <u>12/26/70</u>		23C. PHYSICIAN'S NAME (Type) <u>S. BASU</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/31/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Macedonia Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Northumberland Co. Va.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1970</u>		25B. NAME OF REGISTRAR <u>Walter E. Taylor, Jr.</u>	
25C. FUNERAL DIRECTOR <u>Kelson F.H.</u>		25D. ADDRESS <u>1348 N. Calhoun St.</u>		25E. ADDRESS <u>V.R. Bailey</u>	

V.S. 153

1-21-71

M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12585	
BIRTH NO. 70 12585				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>LAYTON, LUCILLE E.</u>			2. DATE AND HOUR OF DEATH <u>12-25-70</u> <u>8:PM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1548</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 LUTHERAN HOSPITAL</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>46 LUTHERAN HOSPITAL</u>			E. STREET AND NUMBER <u>2206 ROSLYN AVE</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-14-16</u>	9. AGE (In years last birthday) <u>54</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitress</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Apt. Bldg.</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>
13. FATHER'S NAME <u>????</u>			14. MOTHER'S MAIDEN NAME <u>????</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>212-22-4304</u>		
17. INFORMANT <u>Margaret Layton</u>			ADDRESS <u>2206 Roslyn Ave</u>		
18. <u>436.7</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>pulmonary aspiration</u> (B) <u>CVA @ hemiplegia</u> DUE TO, OR AS A CONSEQUENCE OF: <u>43 days</u> (C) _____		
19A. DATE OF OPERATION <u>12-25-70</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <u>No</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>12-17-1970</u> to <u>12-25</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>12-25</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Myung Duck Ro</u>			23B. DATE SIGNED <u>12-25-1970</u>		
23C. PHYSICIAN'S NAME (Type) <u>Myung Duck Ro</u>			23D. ADDRESS <u>Lutheran Hospital 730 Ashburton St.</u>		
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>12-30-70</u>		
24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1970</u>			25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		
25C. FUNERAL DIRECTOR <u>Nutter Funeral Home</u>			ADDRESS <u>3035 W. North Ave</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12586	
BIRTH NO. 70 12586		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>CAROLINE (JULIA) SEMENENIA</u>		2. DATE AND HOUR OF DEATH <u>12/25/70</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>625 S. LUZERNE AVE</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>103</u>	
5. SEX <u>FEMALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>1/24/1891</u>		9. AGE (In years lost birthday) <u>79</u>		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>KULLMAN</u>		14. MOTHER'S MAIDEN NAME <u>WESSEL</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>115-09-3592</u>		17. INFORMANT <u>MRS. F. MIEDUSIEWSKI</u>	
18. <u>151.9 I</u>		CAUSE OF DEATH <u>Cancer of stomach &amp; metastasis to liver.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>March</u> 19 <u>70</u> to <u>12/25</u> 19 <u>70</u> that (I) ( <del>we</del> ) last saw the deceased alive on <u>12/24</u> 19 <u>70</u> and that (in my) ( <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>Joseph R. Alberto, MD</u>		23B. DATE SIGNED <u>12/28/70</u>		23C. PHYSICIAN'S NAME (Type) <u>JOSEPH R. ALBERTO MD</u>	
23D. ADDRESS <u>3508 Bond St Baltimore, Maryland</u>		23E. NAME OF REGISTRAR <u>Robert E. Taylor MD</u>		23F. FUNERAL DIRECTOR <u>Raymond L. Kaczorowski</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/29/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery Baltimore MD.</u>	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1970</u>		24F. ADDRESS <u>2525 FLEET ST.</u>	

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

2. In the second part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

3. In the third part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

4. In the fourth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

5. In the fifth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

6. In the sixth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

7. In the seventh part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

8. In the eighth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

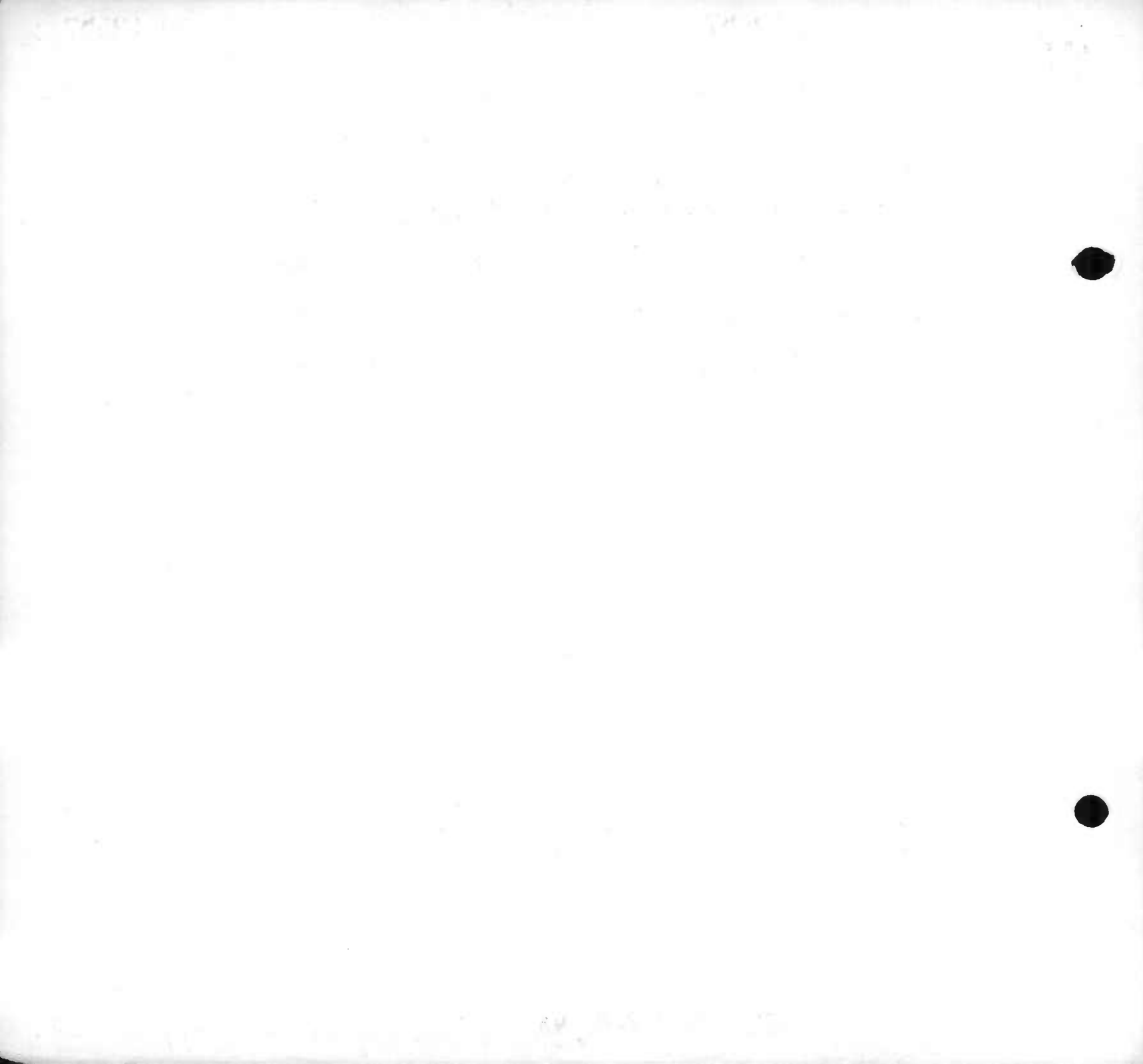
9. In the ninth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

10. In the tenth part of the paper, the author discusses the structure of the atom in more detail. He shows that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are based on the principle of the conservation of energy.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 12587</u>
BIRTH NO. <u>70 12587</u>		1. NAME OF DECEASED (Type or Print) <u>Lilly, Clarence Earl</u>		
2. DATE AND HOUR OF DEATH <u>12/28/70</u> <u>11 26 A.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Church Home &amp; Hospital</u> <u>Broadway &amp; Fayette St. 2123</u>		A. STATE <u>Maryland</u> B. COUNTY <u>2636</u>		
C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>1306 BONSAI Street 21224</u>				
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/21/13</u>
9. AGE (In years last birthday) <u>57</u>		10. DATE OF BIRTH		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dept. Manager</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Hochschild Kohn</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>
13. FATHER'S NAME <u>Oliver V. Lilly</u>		14. MOTHER'S MAIDEN NAME <u>Sue Ann Bowling</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>232-12-5214</u>		17. INFORMANT <u>Mrs. Louise Lilly - 1306 Bonsai St.</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>4-12-21 + 9-3-1-2</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>VENTRICULAR FIBRILLATION</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 mins.</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) INTRAVENTRICULAR CONDUCTION DEFECT DUE TO, OR AS A CONSEQUENCE OF: <u>10 days.</u>		
		(C) ASCVD. and HCV Dr PULM. EDEMA <u>unknown.</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Recurrent LVA, Jandice prot 2° germ hepatitis.</u>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (H) (this hospital) attended the deceased from <u>12-15</u> 19 <u>70</u> to <u>12-28</u> 19 <u>70</u> that (H) (we) last saw the deceased alive on <u>12-28</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Rustum Irani</u>		M.D. DEGREE <u>Attending Phys.</u> <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12/28/70</u>
23C. PHYSICIAN'S NAME (Type) <u>RUSTUM IRANI</u>		23D. ADDRESS <u>M.D. CHURCH HOME AND HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>1-1-71</u>	24C. NAME OF CEMETERY OR CREMATORY <u>BLUERIDGE MEM. GARDENS</u>		24D. LOCATION (City, town, or county) (State) <u>BECKLEY, W. VA.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Martha Gyllen - 2334 Jefferson St.</u>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 12588		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 12588	
1. NAME OF DECEASED (Type or Print) <u>Sherman B. Watts</u>			2. DATE AND HOUR OF DEATH <u>12-27-70</u> <u>5 50</u> PM.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>North Chas General</u> <u>49 Balt. Md</u>			A. STATE <u>Maryland</u> B. COUNTY <u>Anne Arundel</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>PANAMA</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>MALE</u> 6. RACE <u>NEGRO</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			E. STREET AND NUMBER <u>Box 20 RACE ROAD</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>			B. DATE OF BIRTH <u>10-16-19</u> 9. AGE (In years last birthday) <u>51</u>		
10B. KIND OF BUSINESS OR INDUSTRY <u>US Gov.</u>			11. BIRTHPLACE (State or foreign country) <u>Harmans, Md</u>		
13. FATHER'S NAME <u>HARRISON Watts</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
14. MOTHER'S MAIDEN NAME <u>ZORA Oliver</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes World War II</u>		
16. SOCIAL SECURITY NO. <u>220-05-9133</u>			17. INFORMANT <u>Mrs. Esther E. Watts Box 20 Race Road</u> ADDRESS		
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) <u>303.21</u>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Alcoholic Intox.</u> <u>3 d.</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <u>Chronic Alcoholism</u> <u>8 yk</u>		
(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-27-70</u> to <u>12-27-70</u> that (I) (we) last saw the deceased alive on <u>12-27-70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>LK Smith, MD</u>				23B. DATE SIGNED <u>12-28-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>LK Smith, MD</u>				23D. ADDRESS <u>No Chas Genl Hosp.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-31-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Saints Rest Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Anne Arundel Co.</u>		(State) <u>Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC-29-1970</u>	
25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>NUTTER FUNERAL HOME</u>		ADDRESS <u>3035 W. NORTH AVE.</u>	

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BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12589

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MICHAEL T. DIGGS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> <b>December 23, 1970</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4217 Chatham Road</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 23, 1970 11:20 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>2-13-1948</b>		10. AGE (In years lost birthday) <b>22</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Oriole Cleaning</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Oriole Cleaning</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mrs. Alice Diggs</b>		ADDRESS <b>4223 Oakford Avenue</b>	
19. CAUSE OF DEATH <b>3047</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Intravenous narcotism</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) <b>22</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (if in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>December 24, 1970</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-29-1970</b>	
24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>NUTTER FUNERAL HOME</b>		ADDRESS <b>3035 W. NORTH AV</b>	

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POST 10

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 12590		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12590	
1. NAME OF DECEASED (Type or Print) <b>STERLING Mc WILLIAMS</b>			2. DATE AND HOUR OF DEATH <b>12-24-70 9:30 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LUTHERAN HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>P</b>		
			C. CITY OR TOWN <b>BALTO.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>2923 Presbury St.</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-30-1893</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>Caroline ?</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>238-64-8103</b>		17. INFORMANT ADDRESS <b>Mrs. Virginia Lynch 2923 Presbury St.</b>	
				<b>A Mr. Eddie McWilliams 32 Abington Ave.</b>	
18. <b>412.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>① Congestive Heart Failure YEARS</b> (B) <b>② HAD WD</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>③ Uremia, Electrolyte Imbalance ; DKA .</b>					
19A. DATE OF OPERATION <b>12-22-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-22-70</b> 19 <b>70</b> to <b>12-24-70</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>12-24-70</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Angelita O. Topacio</b>			23B. DATE SIGNED <b>12-24-70</b>		
23C. PHYSICIAN'S NAME (Type) <b>ANGELITA TOPACIO, M.D.</b>			23D. ADDRESS <b>LUTHERAN HOSPITAL, BALTO. MD 21248</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-29-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Family Lot</b>	
				24D. LOCATION (City, town, or county) (State) <b>Enfield North Carolina</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>NUTTER FUNERAL HOME 3035 W. NORTH</b>	



70 12591

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 12591

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES WATKINS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> December 23, 1970 Hour: 9:55 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>34 Bon Secours Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year December 23, 1970 Hour: 9:55 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10-14-1894		10. AGE (In years lost birthday) 76	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cafeteria employee		14B. KIND OF BUSINESS OR INDUSTRY Continental Can Co	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 227-07-3338	
15. MOTHER'S MAIDEN NAME Bessie ?		18. INFORMANT Mrs. Elizabeth Anthony	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Fracture of left knee		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12-23-70 about 5:20 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2116 Penrose Avenue		22F. HOW DID INJURY OCCUR? Fell down cellar stairs	
21. AUTOPSY? (Yes or No) Yes			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Charles S. Springate</i> M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED December 24, 1970			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial 12		24B. DATE 12-27-70	
24C. NAME OF CEMETERY or CREMATORY Family Lot		24D. LOCATION (City, town, or county) (State) Petersburg Va.	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1970		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH AV	

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70 12592

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12592

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Lee D. Wright		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HOSPITAL OR INSTITUTION		3. DATE PRONOUNCED DEAD Month Day Year 12 23 1970 7:32 a M.	
10. AGE (In years lost birthday) 79		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1504	
6. SEX male	7. RACE negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto.
9. DATE OF BIRTH 8-27-1891	11. BIRTHPLACE (State or foreign country) Essex Co. Virginia	12. CITIZEN OF WHAT COUNTRY? USA	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) press operator		14B. KIND OF BUSINESS OR INDUSTRY Waverly Press	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 217-01-9115A	
18. INFORMANT Mrs. Jennie E. Wright		ADDRESS 1917 Pulaski St	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-29-1970	
24C. NAME OF CEMETERY or CREMATORY Family Lot		24D. LOCATION (City, town, or county) (State) Essex Co. Virginia	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1970		25B. NAME OF REGISTRAR Robert E. Jones	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH AV.	



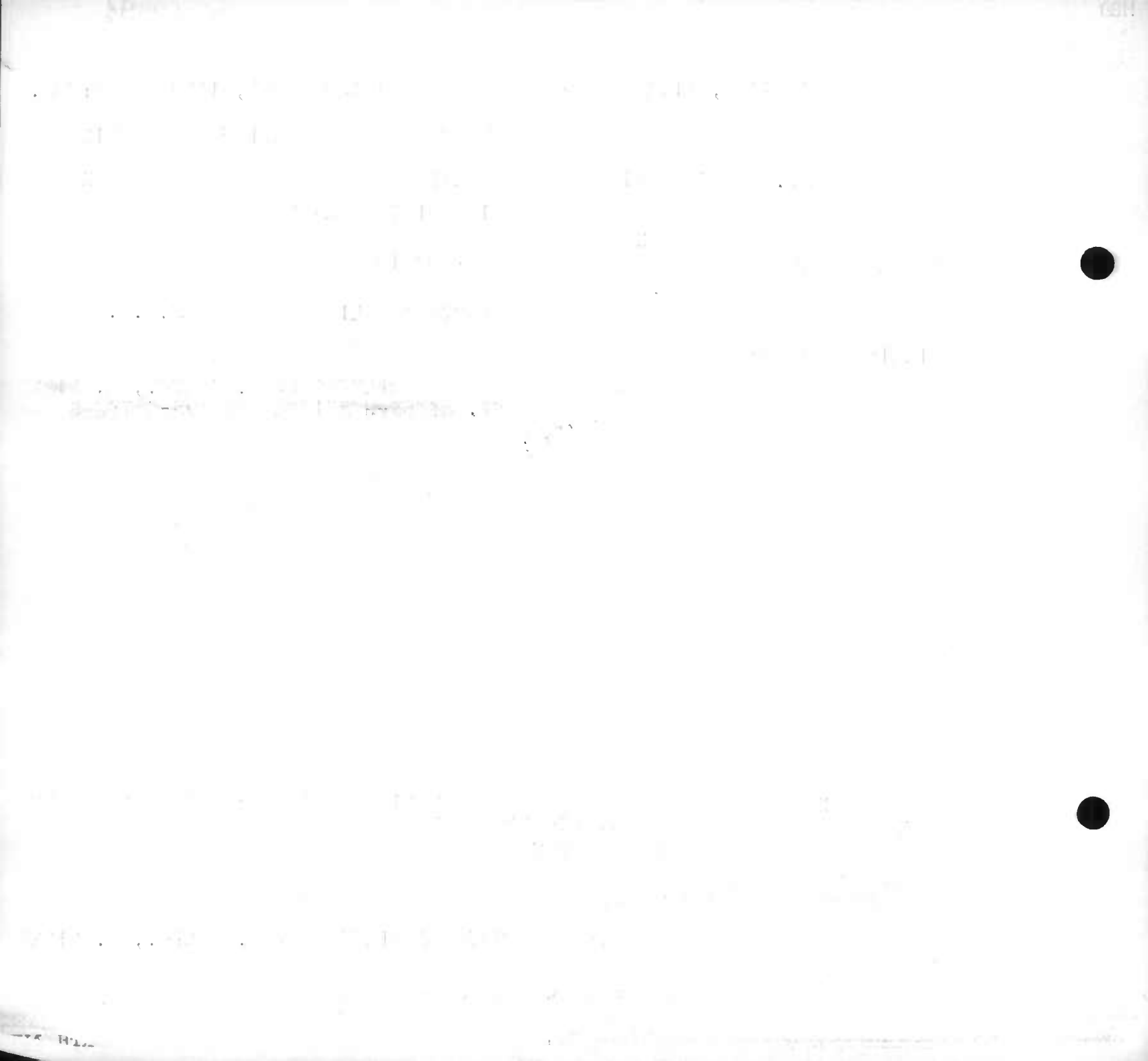
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 12593		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 70 12593	
1. NAME OF DECEASED (Type or Print) DAILEY, EDNA IRENE			2. DATE AND HOUR OF DEATH 12 26 70 7:55 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND ANNE ARUNDEL 5200 C. CITY OR TOWN SEVERN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER BOX 225 CLARKS STATION ROAD		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06 09 06	9. AGE (In years last birthday) 64	10. Under 1 Yr. Months Days 11 Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME GEORGE DAILEY			14. MOTHER'S MAIDEN NAME ELVA CULVER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ---	17. INFORMANT MR. JACK DAILEY BOX 44 WRIGHTS ROAD		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Severe bleeding. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute ulcers of stomach unknown (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ----- ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes mell - ASCVD -			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 wks.		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II					
19A. DATE OF OPERATION 11-4-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED gangrene right leg		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 11 09 19 70 to 12 26 19 70 that (X) (we) last saw the deceased alive on 12 26 70 19 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (we) view the body after death.					
23A. SIGNATURE Rose After, M.D.			23B. DATE SIGNED 12/27/70		23C. PHYSICIAN'S NAME (Type) Rose After, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-30-70		24C. NAME OF CEMETERY OR CREMATORY Saints Rest Cemetery	
24D. LOCATION (City, town, or county) (State) ANNE ARUNDEL CO. MD.		25A. DATE REC'D BY HEALTH DEPT. DEC 29 1970			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12594		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X 70 12594	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JACKSON, RICKER		DECEMBER 24, 1970 5:00A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		A. STATE B. COUNTY MARYLAND BALTIMORE 21228			
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 16 1/2 WINTERS LANE		5300	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02 09 10	9. AGE (in years last birthday) 60	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM JACKSON		14. MOTHER'S MAIDEN NAME Mary O'Neal	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Gilbert Jackson 16 1/2 Winters Lane	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 571.0 I Alcoholic hepatitis hepatic coma, Anoxia of the liver -		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) The liver -		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH undetermined	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from DECEMBER 21 19 70 to DECEMBER 24 19 70 that (X) (we) lost saw the deceased alive on DECEMBER 24 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE Bizhan Ebrahimi		23B. DATE SIGNED 12-24-70			
23C. PHYSICIAN'S NAME (Type) BIZITAM EBRAHIMI		23D. ADDRESS CATON & WILKENS AVES. BALTO., MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-28-70		24C. NAME of CEMETERY or CREMATORY Western Star Cemetery, Baltimore Co. Maryland	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. DEC 29 1970		25B. NAME OF REGISTRAR Robert E. Taber, M.D.	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12595		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12595	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HARRY E. TRIBBITT</b>		2. DATE AND HOUR OF DEATH <b>12/27/70 10:50 AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Lutheran Hospital 730 Ashburton St.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1547</b>		C. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>3219 Windsor Avenue</b>	
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-20-88</b>	9. AGE (In years last birthday) <b>82</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>auto mechanic</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>? ? ?</b>		14. MOTHER'S MAIDEN NAME <b>? ? ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>143-10-6147A</b>		17. INFORMANT <b>Rev. Harold I. Williams</b>	
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac failure.</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic Cardio-vascular disease</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) <b>Partial Obstruction &amp; megacolon</b> <b>2) Carcinoma Prostate?</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>NO INJURY</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>12/29/1970</b> to <b>12/27/1970</b> that (I) (we) last saw the deceased alive on <b>12/27/1970</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>K George Thomas MD</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>K GEORGE THOMAS</b>		23D. ADDRESS <b>Lutheran Hospital of MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12-31-70</b>	24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>		25C. FUNERAL DIRECTOR <b>NUTTER FUNERAL HOME 3035 W. NORTH AVE</b>	



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70 12596

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12596

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Henry G. Miller		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 25 70 11:15 a M.	
6. SEX male		7. RACE colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 6-15-1915		10. AGE (In years lost birthday) 55	
11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed-Laborer		15. MOTHER'S MARDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT ADDRESS Phyllis Loudon - 1433 Homestead St.		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 900 Blk. N. Dallas St. 704		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 11 24 70 ? a m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? shot during altercation	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Partial Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. BURIAL CREMATION, REMOVAL (Specify) Removal	
24B. DATE 12-31-70		24C. NAME OF CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county) (State) Charlotte, N. Carolina		25A. DATE REC'D BY HEALTH DEPT. DEC 29 1970	
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR PERKINS Funeral Home - 11290 Caroline St.	

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70 12597

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 12597

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ADDRESS OR LOCATION		3. DATE PRONOUNCED DEAD Month Day Year Hour		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY	
6. SEX male		7. RACE negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 12-18-48		10. AGE (In years lost birthday) 22		11. BIRTHPLACE (State or foreign country) Maryland U.S.A.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Charles Dobbins Sr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed-Laborer	
15. MOTHER'S MAIDEN NAME Mable Porter		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Mable Dobbins-1705 Homestead St.		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural Causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-25-70					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-30-70		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION (City, town, or county) (State) Arbutus, Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 29 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR 2115 1st Ave. N. Carolina St.		25D. ADDRESS		25E. ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

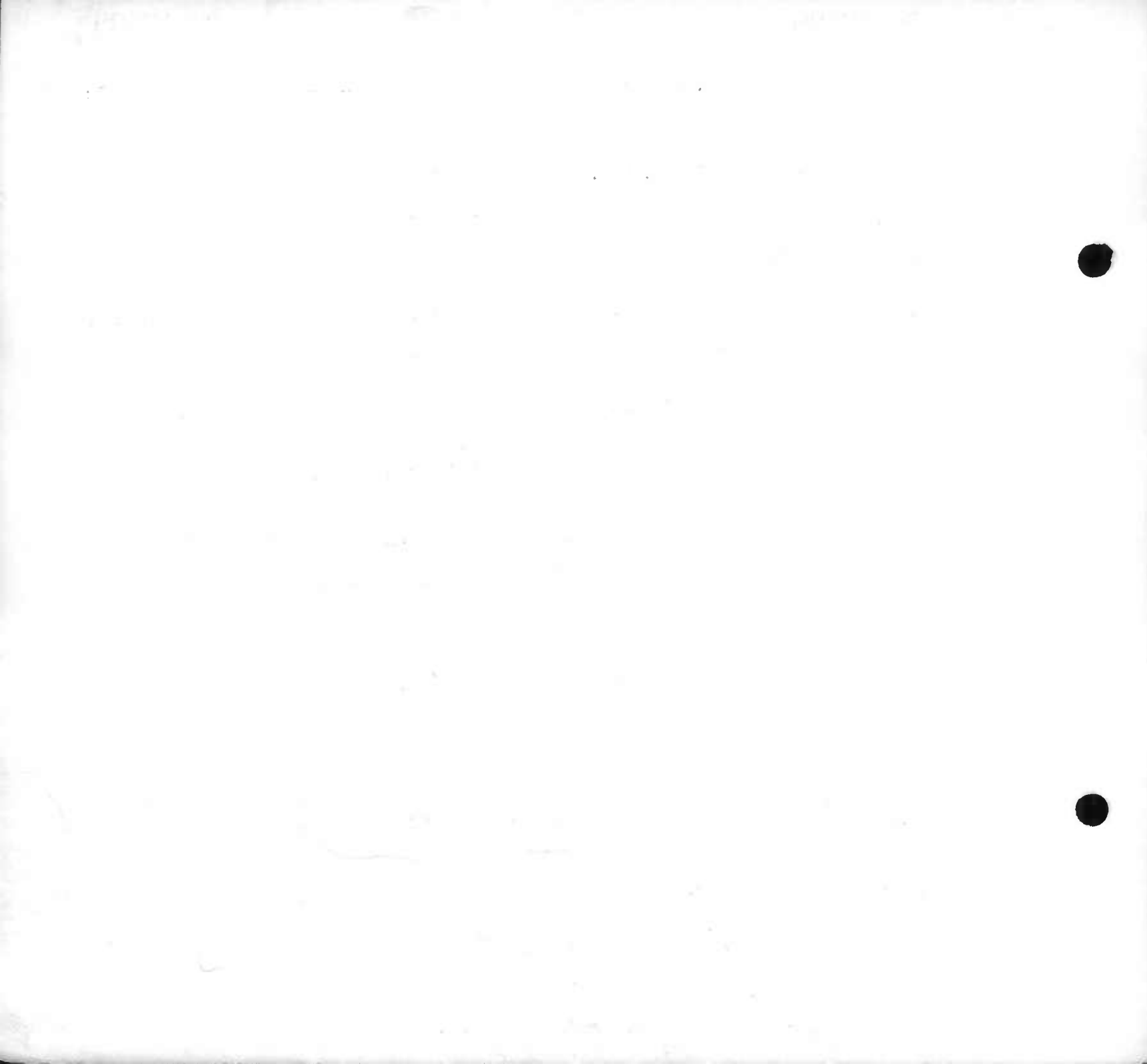
BALTIMORE CITY HEALTH DEPARTMENT				70 12598	
CERTIFICATE OF DEATH				70 12598	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WILLIAM TURNER		12/25-70 10 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital			A. STATE Maryland		
			B. COUNTY 1204		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 322 E. 22nd 1/2 street		
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8/27/20	9. AGE (In years last birthday) 50
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John D. Turner			14. MOTHER'S MAIDEN NAME Rosa Carter		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Rosa Turner 3705 W. Franklin St.	
18. CAUSE OF DEATH 314 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 12/23/1970 to 12/25/1970 that (I) (we) last saw the deceased alive on 12/25/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE J. Khoury 23B. DATE SIGNED 12/25/70 23C. PHYSICIAN'S NAME (Type) JACQUES KHOURY 23D. ADDRESS Union Memorial Hospital 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 12-30-70 24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery 24D. LOCATION (City, town, or county) (State) B. A. County Md. 25A. DATE REC'D BY HEALTH DEPT. DEC 29 1970 25B. NAME OF REGISTRAR Ruth E. Fisher, R.D. 25C. FUNERAL DIRECTOR Clifford L. H. 11297 Calhoun St. ADDRESS					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12599	
BIRTH NO. 70 12599		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Florence E. Koskey		2. DATE AND HOUR OF DEATH 12-28-70 1:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital, Inc.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 419 S. Chapel Street			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/19/92	9. AGE (In years last birthday) 78	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Richard Syples		14. MOTHER'S MAIDEN NAME Charlotte Walsh	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) - -		16. SOCIAL SECURITY NO. 213-01-2126		17. INFORMANT Miss Evelyn Koskey, 419 S. Chapel St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PNEUMONITIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 12/20/70 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (A) (this hospital) attended the deceased from 12/20/70 to 12/28/70 that (B) (we) last saw the deceased alive on 12/28/70 and that (C) (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (D) (We) (did) (did not) view the body after death. 23A. SIGNATURE [Signature] 23B. DATE SIGNED 12/28/70 23C. PHYSICIAN'S NAME (Type) Molony 23D. ADDRESS Mercy Hospital, Baltimore, Md. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 12/31/70 24C. NAME OF CEMETERY OR CREMATORY New Cathedral 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 25A. DATE REC'D BY HEALTH DEPT. DEC 29 1970 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. 25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE 25D. ADDRESS					



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BALTIMORE CITY HEALTH DEPARTMENT									
70 12600 MEDICAL EXAMINER'S CERTIFICATE OF DEATH					REG. NO. 70 12600				
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) Mikolaj Mazur A/K as Nicholas Mazur					2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 12 Day 27 Year 70 Estimated <input type="checkbox"/> 9:45 a. M.				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 245 S. Ellwood Avenue Ellwood					3. DATE PRONOUNCED DEAD Month 12 Day 27 Year 70 9:45 a. M.				
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 102									
6. SEX male		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 12/2/21		10. AGE (in years lost birthday) 49		11. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 245 S. Ellwood Avenue 21224			
11. BIRTHPLACE (State or foreign country) Poland				12. CITIZEN OF WHAT COUNTRY? Poland		13. FATHER'S NAME Wojciech Mazur			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				14B. KIND OF BUSINESS OR INDUSTRY Rubber Products		15. MOTHER'S MAIDEN NAME Maria Kogut			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No				17. SOCIAL SECURITY NO. 213-34-0418		18. INFORMANT ADDRESS Mrs. Anna Mazur, 245 S. Ellwood Ave			
19. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE: <i>Peter Lipkovic</i> M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D.  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/28/70									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/30/70		24C. NAME OF CEMETERY or CREMATORY Holy Rosary		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1970		25B. NAME OF REGISTRAR Robert E. Tabor, M.D.		25C. FUNERAL DIRECTOR A. F. SADOWSKI & SONS		ADDRESS 1808 EASTERN AVE			

MEDICAL CERTIFICATION

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
70 12601		CERTIFICATE OF DEATH		70 12601	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Katherine Emma Schultheis			Dec. 25, 1970		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
90 Goidl Convalesarium			Maryland 901		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			3803 Yolando Road		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 27, 1884	85	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
At home			Maryland		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Markert			Charlotte		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Wm. Schultheis, 3803 Yolando Road. 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
4124 I			Uremia		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			Anteriosclerotic CV disease		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			Years		
			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
D					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 5 1969 to DECEMBER 19 1970 that (I) (we) last saw the deceased alive on 12-16 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
RK Gundry				12-24-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Richard K. Gundry, M.D.				2 W, University Park	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12/26/70		Loudon Park Cemetery	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 29 1970		Robert E. Taylor, R.D.		Ulrich Funeral Home, 4210 Belair Road.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K 656 1

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 12602

BIRTH NO. 70 12602

1. NAME OF DECEASED (Type or Print) <b>SARAH KRAMER</b>		2. DATE AND HOUR OF DEATH <b>12/23/70 8:30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>Union Memorial Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>831</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>		C. CITY OR TOWN <b>Baltimore</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>F</b> 6. RACE <b>W</b>		E. STREET AND NUMBER <b>3003 Erdman Avenue</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/15/48</b>	9. AGE (In years last birthday) <b>72</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>American</b>	
13. FATHER'S NAME <b>Jefferson Sickel</b>		14. MOTHER'S MAIDEN NAME <b>McLaughlin Margaret</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-38-7421</b>	
17. INFORMANT <b>MRS MARGARET BUTTS-1000 DUNDANE RD</b>		ADDRESS	
18. <b>4100 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>Cardiac arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Acute inf. MI</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/22</b> 19 <b>70</b> to <b>12/23</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>12/23</b> 19 <b>70</b> and that (n)(my) (aur) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Jacques Khoury</b>		23B. DATE SIGNED <b>12/23/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>JACQUES KHOURY</b>		23D. ADDRESS <b>Union Memorial Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/24/70</b>	
24C. NAME of CEMETERY or CREMATORY <b>MORELAND PARK 5</b>		24D. LOCATION (City, town, or county) (State) <b>PARKVILLE MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson, M.D.</b>	
25C. FUNERAL DIRECTOR <b>ULLRICH FUNERAL HOME-4210 BELAIR</b>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12608	
BIRTH NO. 70 12603				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Raymond C. Schoeberlein</b>			2. DATE AND HOUR OF DEATH <b>12/26/70</b> <b>3<sup>20</sup> P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION <b>The Joltus Hopkins Hospital</b> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <b>33</b>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2605</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> E. STREET AND NUMBER <b>6817 Gough St.</b>		
5. SEX <b>male</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 14, 1953</b>		9. AGE (in years last birthday) <b>17</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Constable</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Peoples Court</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>JOHN SCHOEBERLEIN</b>			14. MOTHER'S MAIDEN NAME <b>FREDERICKA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-01-5078</b>		17. INFORMANT <b>Mrs. Dotie Schoeberlein</b> <b>Same as #4E</b>	
18. <b>4/12/21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cerebral + Brain Stem Infection</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hypertensive Cardiovasc. Dis</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>15 yrs.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/25</b> 1970 to <b>12/26</b> 1970, that (I) (we) last saw the deceased alive on <b>12/26</b> 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Robert A. Vigersky, M.D.</b>				23B. DATE SIGNED <b>12/26/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert A. Vigersky</b>		23D. ADDRESS <b>601 N. Broadway, Baltimore Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-30-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>London Park Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore</b>		24E. STATE <b>Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Faber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, Inc.</b>	
25D. ADDRESS <b>Towson, Md.</b>					



70 12604

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 12604

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>FRANK LIN AMBROSE MILLER</b> <b>FRANK MILLER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1516 Baldwin St.</b> <b>1-8-71</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 25 1970 9:28 a</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1348</b>		6. SEX <b>male</b> 7. RACE <b>white</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH <b>July 21 1921</b>		10. AGE (In years lost birthday) <b>49</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTH PLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
15. MOTHER'S MAIDEN NAME <b>CORA E. Satch</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>	
17. SOCIAL SECURITY NO. <b>213 16 9902</b>		18. INFORMANT <b>William S Miller</b>	
19. CAUSE OF DEATH <b>30371</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. DATE OF OPERATION <b>2</b> 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Acute ethylism</b> <b>fatty liver</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>chronic alcoholism</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
21. AUTOPSY? (Yes or No) <b>PARTIAL</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-28-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Merchewridge Memph</b>		24D. LOCATION (City, town, or county) (State) <b>Howard Co Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Burgess Funeral Home</b>		25D. ADDRESS <b>Baltimore Md</b>	

MI 13804

ACADEMY BOARD

MI 13804

ACADEMY BOARD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

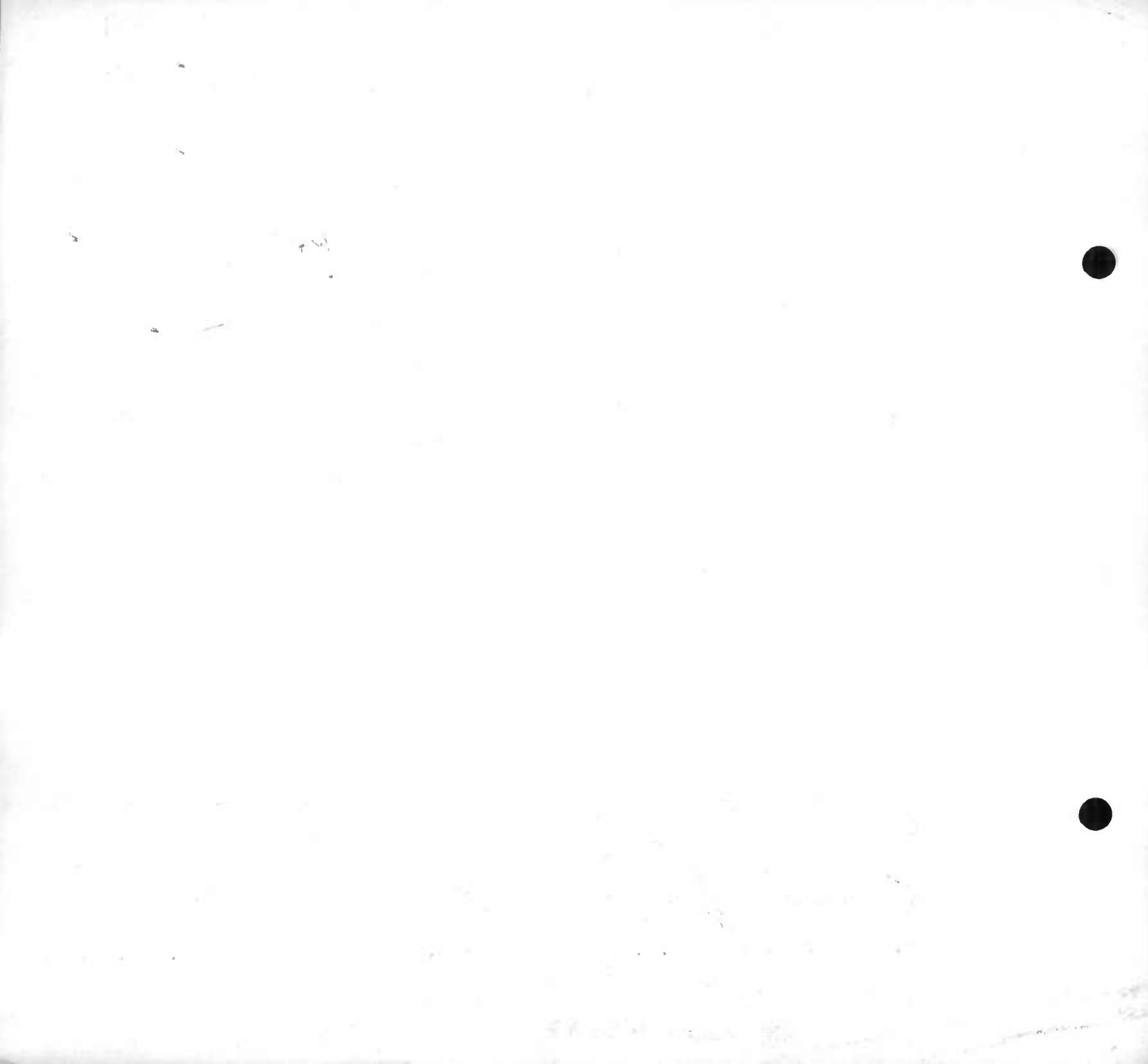
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12605</u>	
BIRTH NO. <u>70 12605</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>MARY E SHEFFER</u>			2. DATE AND HOUR OF DEATH <u>12/24/70</u> <u>9:15 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1348</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>1326 Weldon Avenue</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03/16/95</u>	9. AGE (In years last birthday) <u>75</u>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Life Ins Office</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>Harry Weaver</u>			14. MOTHER'S MAIDEN NAME <u>Ella Ney</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-20-3674-A</u>		17. INFORMANT <u>Harry B Sheffer</u>	
				ADDRESS <u>4403 Chapeledale Rd</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. If means the disease, injury or complication which caused death.) <u>427.2 I</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac arrest</u>  (B) <u>Heart attack</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>12/20</u> 19 <u>70</u> to <u>12/24</u> 19 <u>70</u> that (I) <u>we</u> last saw the deceased alive on <u>12/24</u> 19 <u>70</u> and that in (my) <u>we</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) <u>did not</u> view the body after death.					
23A. SIGNATURE <u>J. Khoury</u>			23B. DATE SIGNED <u>12/24/70</u>		
23C. PHYSICIAN'S NAME (Type) <u>JACQUES KHOURY</u>			23D. ADDRESS <u>Union Memorial Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>12 29 70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Union Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>MANCHESTER PA.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Faboy, M.D.</u>		25C. FUNERAL DIRECTOR <u>BURGEE FUNERAL HOME</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 12606		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 12606	
1. NAME OF DECEASED (Type or Print) <u>Lucy Arrington</u>			2. DATE AND HOUR OF DEATH <u>Dec. 23, 1970</u> <u>9 A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Carver Nursing Home</u> <u>607 Penn Ave</u>			A. STATE <u>Maryland</u> B. COUNTY <u>2001</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2009 W. Mulberry St.</u>		
5. SEX <u>Female</u>	6. RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 4, 1891</u>	9. AGE (In years last birthday) <u>79 yrs</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic work</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>unknown</u>			14. MOTHER'S MAIDEN NAME <u>unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>23862-89920</u>	17. INFORMANT <u>Chart</u>		ADDRESS <u>607 Penn Ave</u>
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>GENERALIZED ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>YRS.</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>NO</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>7-27-</u> 19 <u>70</u> to <u>12-23-</u> 19 <u>70</u> that (1) (we) lost saw the deceased alive on <u>12-18-</u> 19 <u>70</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard Tyson, M.D.</u>			23B. DATE SIGNED <u>12/23/70</u>		
23C. PHYSICIAN'S NAME (Type) <u>Dr. Richard Tyson M.D.</u>			23D. ADDRESS <u>936 W. North Avenue Balto. Md. 21217</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>12/29/70</u>	24C. NAME of CEMETERY or CREMATORY <u>Mt Calvary Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>A A County Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u> 1206 W North A	



5530

70 12607

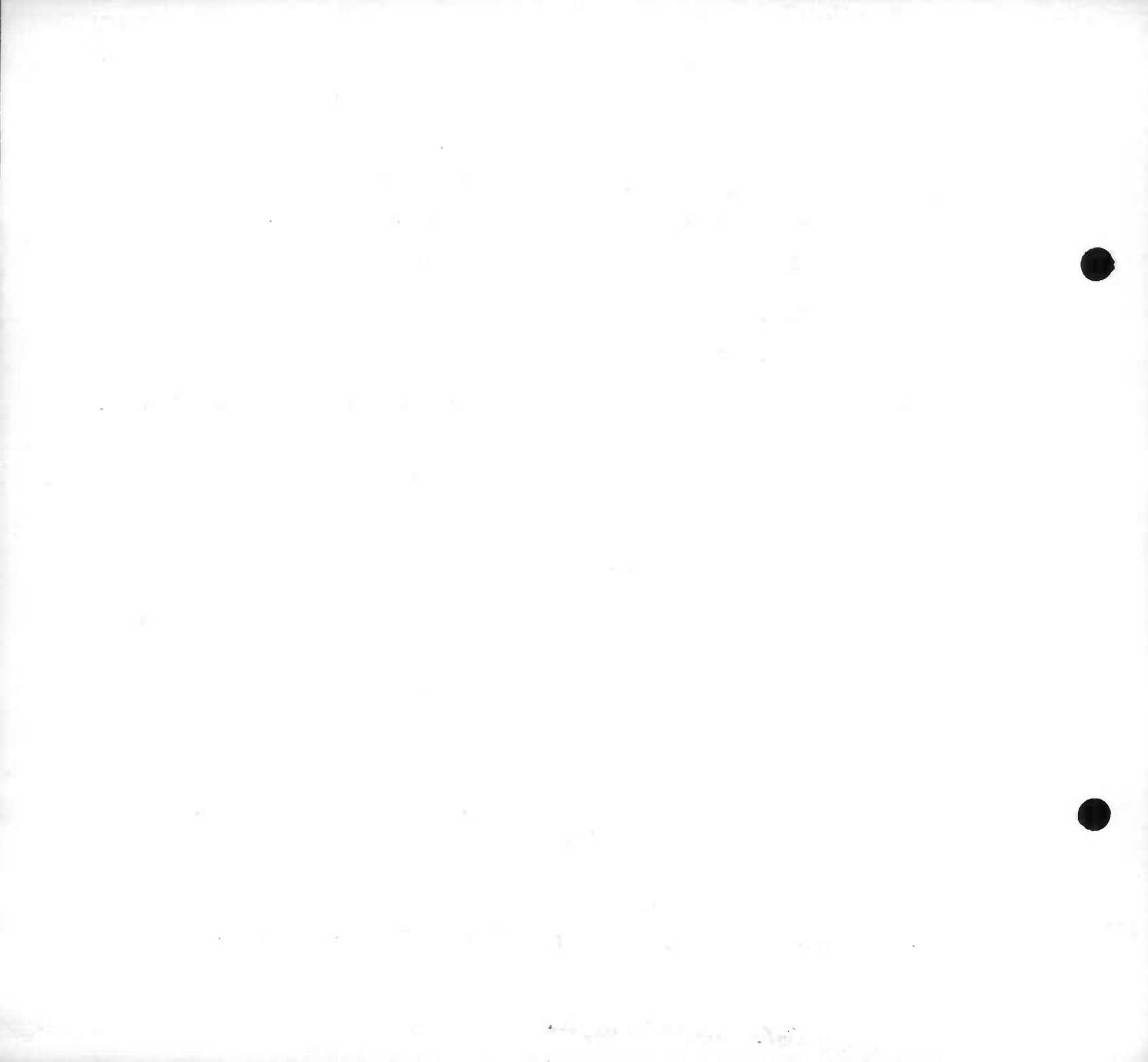
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 12607

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Thomas Edward/Smith</b>		2. DATE AND HOUR OF DEATH <b>Dec. 20, 1970</b> <b>7</b> <b>P</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>402</b>		5. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>US Public Health Service Hospital</b> <b>3100 Wyman Parkway</b>		E. STREET AND NUMBER <b>? 743 W. Fayette St.</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>M</b>	7. RACE <b>col</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. DATE OF BIRTH <b>2/20/24 ?</b>	10. AGE (In years last birthday) <b>46</b>	11. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>? NC</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>? Charlie Smith</b>		14. MOTHER'S MAIDEN NAME <b>? Cora Knight</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>? 485X</b>		16. SOCIAL SECURITY NO. <b>241-30-3509</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>BRONCHOPNEUMONIA</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Bronchopneumonia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <b>II</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Portal cirrhosis</b>		Years	
19A. DATE OF OPERATION <b>7</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>Dec. 11</b> 19 <b>70</b> to <b>Dec. 20</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>Dec. 20</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>R. Roger Little</b> DEGREE	
23B. DATE SIGNED <b>12/23/70</b>		23C. PHYSICIAN'S NAME (Type) <b>R. Roger Little, Surg (R)</b> DEGREE		23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/29/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt C lvary Cemetry</b>	
24D. LOCATION (City, town, or county) (State) <b>AA County Md</b>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Adolphuws Halstead</b>		25D. ADDRESS <b>1206 W 14 orth A v e</b>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



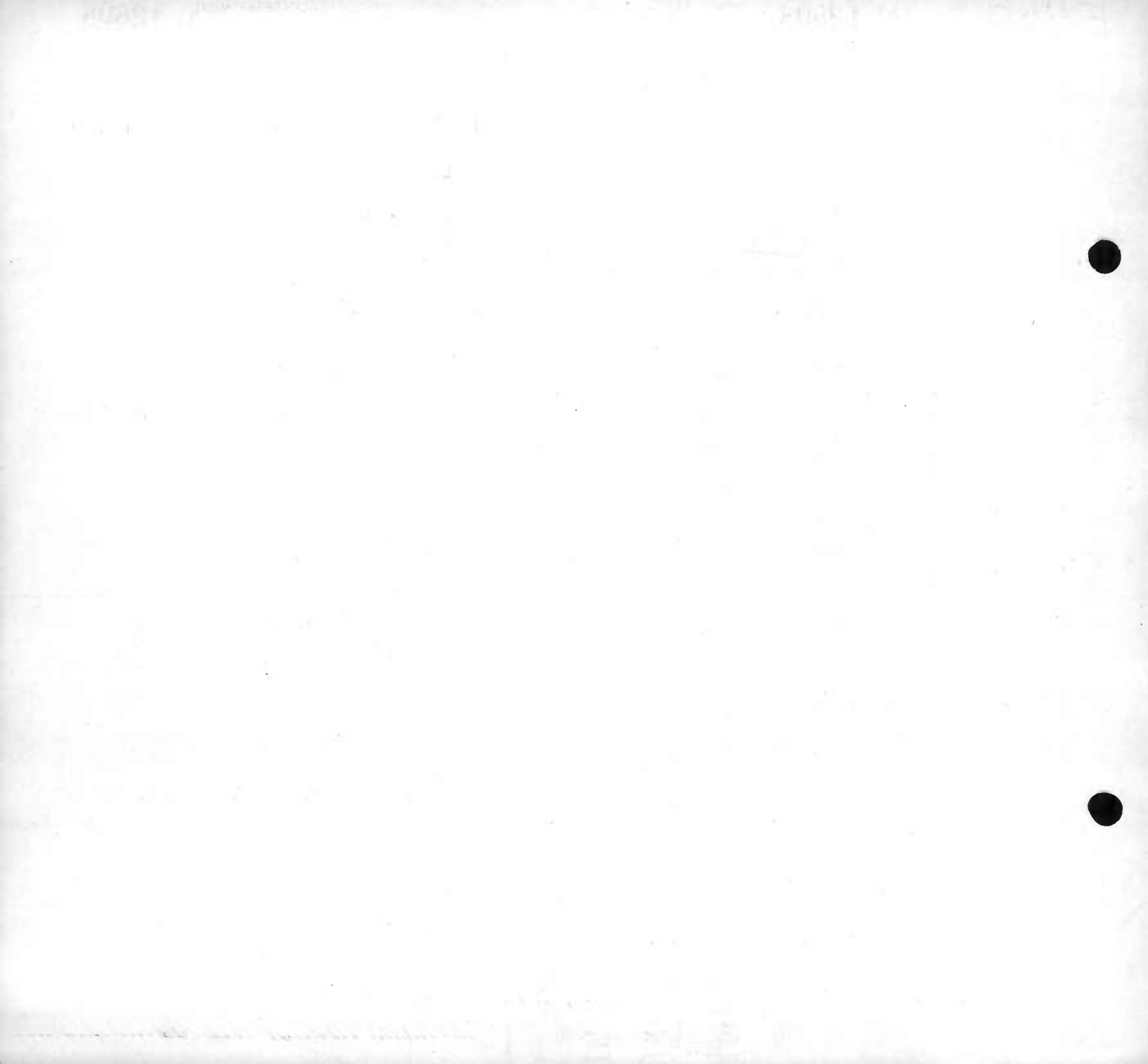
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12608

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 12608

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Samuel Falcon		Dec. 24, 1970 19:10 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE MARYLAND	
Johns Hopkins Hospital				B. COUNTY BALTIMORE CITY	
				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1931 W. EEXINGTON STREET	
5. SEX M		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6-24-27		9. AGE (In years last birthday) 43		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement finisher	
11. BIRTHPLACE (State or foreign country) Henderson N.C.		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Richard Falcon	
14. MOTHER'S MAIDEN NAME Luberta Lewis		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 920-22-6476	
17. INFORMANT Loretta Falcon		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CARCINOMA, Primary site not known ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		19. ADDRESS 1931 W. EEXINGTON ST.	
20. A. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 21. DUE TO, OR AS A CONSEQUENCE OF: 22. DUE TO, OR AS A CONSEQUENCE OF:		23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 months		24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
25. DATE OF OPERATION 2		26. CONDITION FOR WHICH OPERATION WAS PERFORMED		27. A. AUTOPSY? (Yes or No) YES	
28. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		29. A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		30. B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
31. C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		32. D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		33. E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
34. F. HOW DID INJURY OCCUR?		35. I certify that (I) (this hospital) attended the deceased from Nov. 25, 1970 to Dec. 24, 1970 that (I) (we) last saw the deceased alive on Dec. 24, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.		36. SIGNATURE Douglas L. Hurley, MD	
37. PHYSICIAN'S NAME (Type) DOUGLAS L. HURLEY, M.D.		38. ADDRESS JOHNS HOPKINS HOSPITAL		39. DATE SIGNED 12/24/70	
40. A. BURIAL CREMATION, REMOVAL (Specify)		41. B. DATE 12/29/70		42. C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. Balto. Md	
43. D. LOCATION (City, town or county) (State)		44. E. NAME OF REGISTRAR Robert E. Fisher, Jr.		45. F. FUNERAL DIRECTOR Williams Funeral Home 317 N. Schuyler	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		70 12609	
BIRTH NO. 70 12609				CERTIFICATE OF DEATH		REG. NO. 70 12609	
1. NAME OF DECEASED (Type or Print) Minnis W. Molloy				2. DATE AND HOUR OF DEATH Dec. 29, 1970 5:30 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Edgewood Nursing Home				4. USUAL RESIDENCE (Where deceased lived, If institution residence before admission) A. STATE B. COUNTY Maryland B2110 5300 C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 236 St. David Court			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-24-1883	9. AGE (In years last birthday) 87	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress			10B. KIND OF BUSINESS OR INDUSTRY Sewing		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Kolbe				14. MOTHER'S MAIDEN NAME Nannie Howard			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 220-30-5218		17. INFORMANT ADDRESS Mrs. Nancy M. Chiodi 236 St. Davids Court		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 412.41 [This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral thrombosis 8 years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(B) Arteriosclerotic cardiovascular disease 7 years			
				(C)			
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Apr 15 1970 to Dec 29 1970 that (I) (we) last saw the deceased alive on Dec 28 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Frederick J. Vollmer M.D. DEGREE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-29-70	
23C. PHYSICIAN'S NAME (Type) Dr. Frederick J. Vollmer				23D. ADDRESS 6100 York Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 1970 12-30-		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1970		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12610		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12610	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		John Whitney Bates		Dec. 28, 1970 12 <sup>30</sup> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> FULL NAME OF DECEASED (If not in hospital or institution, give street address or location) 1-11-71 00 526 W. University Parkway			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY Maryland 1307		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 526 W. University Parkway		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-3-1904	9. AGE (In years last birthday) -67- 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd. District Rep.		10B. KIND OF BUSINESS OR INDUSTRY Commercial Credit		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Whitney Bates		14. MOTHER'S MAIDEN NAME Blanche Feelemeyer	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 240-07-2952		17. INFORMANT Mrs. Margaret S. Bates	
				ADDRESS Same	
18. I <u>3719</u> I <u>1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary of heart</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1960</u> 19 <u>Dec</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>Dec 27</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>W. G. Helfrich</i> 23C. PHYSICIAN'S NAME (Type) Dr. William G. Helfrich				23B. DATE SIGNED 12-28-70	
23D. ADDRESS 5006 Roland Avenue					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-30-1970 12-28-1970		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1970		25B. NAME OF REGISTRAR Robert E. Jaber		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Road Balto., Md.	

V.S. 153

1-11-71

M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B 600 1

70 12611

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

70 12611

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Charles H. Boyer

2. DATE AND HOUR OF DEATH

Dec. 28, 1970

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1-4-71

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1231 Gittings Ave.

5. SEX

M

6. RACE

W

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

5-28-07

9. AGE (In years last birthday)

63

10. Under 1 Yr. Months Days

11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Supervisor

10B. KIND OF BUSINESS OR INDUSTRY

Dept. Store H.K.

11. BIRTHPLACE (State or foreign country)

Belair, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Rezin T. Boyer

14. MOTHER'S MAIDEN NAME

Arnida McCann

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

215-05-6852

17. INFORMANT

Mrs. Charles H. Boyer

ADDRESS

Same

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

MYOCARDIAL INFARCTION

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ATHEROSCLEROSIS

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

13 YEARS

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

NONE

19A. DATE OF OPERATION

NONE

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 12-3-70 to 12-28-70 that (I) (~~we~~) last saw the deceased alive on 12-23-70 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (~~did not~~) view the body after death.

23A. SIGNATURE

Leon Ashman

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

12-28-70

23C. PHYSICIAN'S NAME (Type)

Dr. Leon Ashman

23D. ADDRESS

5907 Gwynn Oak Ave.

24A. BURIAL, CREMATION, REMOVAL (Specify)

Entombment

24B. DATE

12-31-70

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Pk. Mausoleum

24D. LOCATION

Baltimore Co.

Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 29 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

H.W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212

V.S. 153

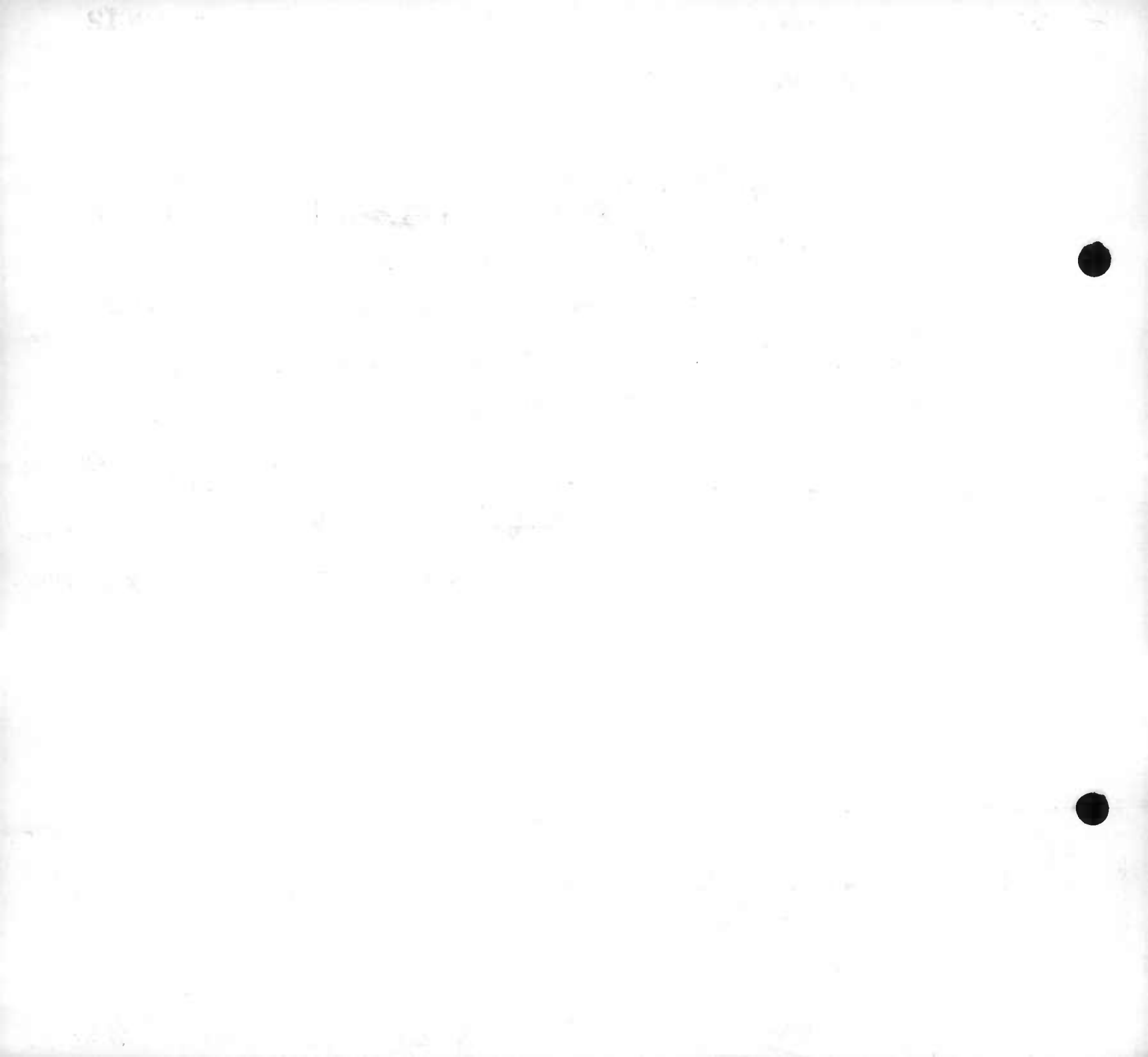
1-4-71

M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12612		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12612	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>ERNEST - HARRIS</b>			2. DATE AND HOUR OF DEATH <b>12/24/70 8<sup>50</sup> AM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital, Balto - Md.</b>			A. STATE <b>Maryland</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>21215</b>			B. COUNTY <b>1348</b>		
			C. CITY OR TOWN <b>Balto</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>1317 - Webster Ave.</b>		
5. SEX <b>M</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/3/27</b>	9. AGE (in years last birthday) <b>43</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Policeman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Police Force</b>	11. BIRTHPLACE (State or foreign country) <b>Balto</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Samuel Harris</b>			14. MOTHER'S MAIDEN NAME <b>Erla May Horvath</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>215 22 5721</b>	17. INFORMANT <b>Mrs Ruth Harris</b>		ADDRESS <b>Somer</b>
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>4/10/91</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>cardiogenic shock - tachycardia</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>possible rupture of ventricle</b>		
			(C) <b>acute extensive A.I. MI</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Hoorazar - 9068</b>				23B. DATE SIGNED <b>12/24/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>HOORAZAR, 9068</b>				23D. ADDRESS <b>Sinai Hospital, Balto, Md 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12-26-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Marshall Memorial Park, Balto Md 21224</b>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Burgess Funeral Home Baltimore</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO. 70 12613

BIRTH NO. 70 12613

1. NAME OF DECEASED  
(Type or Print)

Joseph A Haupt

2. DATE AND HOUR OF DEATH

Dec. 24, 1970 8:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

90 Ardleigh Nursing Home

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Md B. COUNTY 1307

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

1105 Weldon Ave

5. SEX

Male

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

24 Feb 92

9. AGE (In years last birthday)

78

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Foreman

10B. KIND OF BUSINESS OR INDUSTRY

Foundry

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

James A Haupt

14. MOTHER'S MAIDEN NAME

Mary Ellen Cavey

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

212107330

17. INFORMANT

J. Wade Haupt Glen Burnie Md

ADDRESS

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

ARTERIO-SCLEROTIC  
(A) IMMEDIATE CAUSE RADIO-VASCULAR DISEASE  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

5 YRS

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

DIABETES MELLITUS (Mild) 2 YRS.

19A. DATE OF OPERATION

10-31-70  
11-6-70

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

G. I. Bleeding

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec. 5, 1970 to Dec. 24, 1970 that (I) (we) last saw the deceased alive on Dec. 22, 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (do not) view the body after death.

23A. SIGNATURE

Lloyd E. Saylor, M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

LLOYD E. SAYLOR

23D. ADDRESS

BALTIMORE, MD, 21218  
3902 GREENMOUNT AVE.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-28-70

24C. NAME OF CEMETERY or CREMATORY

Druid Ridge Cemetery Parkersville Bk Co Md

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 29 1970

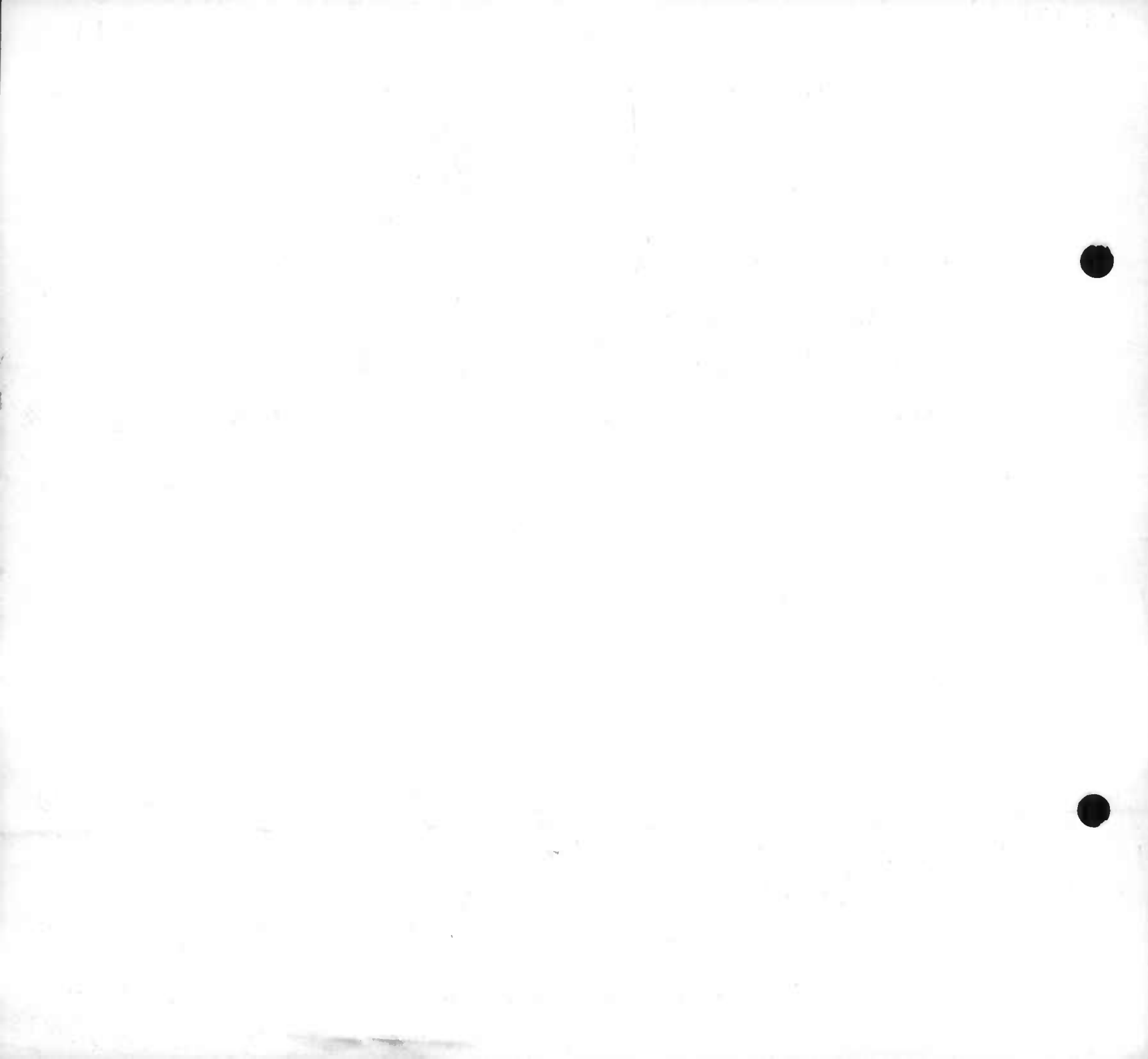
25B. NAME OF REGISTRAR

Robert E. Jarboe, M.D.

25C. FUNERAL DIRECTOR

Burgess Funeral Home Bk Co Md

ADDRESS



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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12614	
BIRTH NO. 70 12614				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Gus George Harris</u>			2. DATE AND HOUR OF DEATH <u>Dec 20 1970</u> <u>145</u> AM.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hospitals</u> <u>1224</u> <u>1940 Eastern Avenue Baltimore, Maryland</u>			4. USUAL RESIDENCE (Where deceased lived, II institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2607</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>405 South Macon Street</u> <u>21224</u>		
5. SEX <u>male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-10-20</u>	9. AGE (In years last birthday) <u>50</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Music Instructor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Music</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Harris</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>World War II</u>			
16. SOCIAL SECURITY NO. <u>217-05-2418</u>		17. INFORMANT <u>4940 Eastern Avenue</u> <u>BCH: Records</u> <u>Baltimore, Maryland</u> <u>21224</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Pneumonia &amp; Septic Shock</u> <u>Hodgkins Disease IV B</u> <u>Cryptococcal meningitis</u> <u>Anemia / CHF / GI Bleeding</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>3 1/2 years</u> <u>5 wks</u>		
19A. DATE OF OPERATION <u>D</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Nov 24</u> 19 <u>70</u> to <u>Dec 20</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>2/20/2 midnight</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>David Juan M.D.</u>			23B. DATE SIGNED <u>Dec 20, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>David Juan M.D.</u>
23D. ADDRESS <u>Baltimore City Hospitals</u> <u>940 Eastern Avenue Baltimore, Maryland 21224</u>			23E. FUNERAL DIRECTOR <u>Nicholas T. Matthews</u> <u>3021 Eastern Ave., Baltimore, Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-23-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u> <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. ADDRESS <u>3021 Eastern Ave., Baltimore, Md.</u>	

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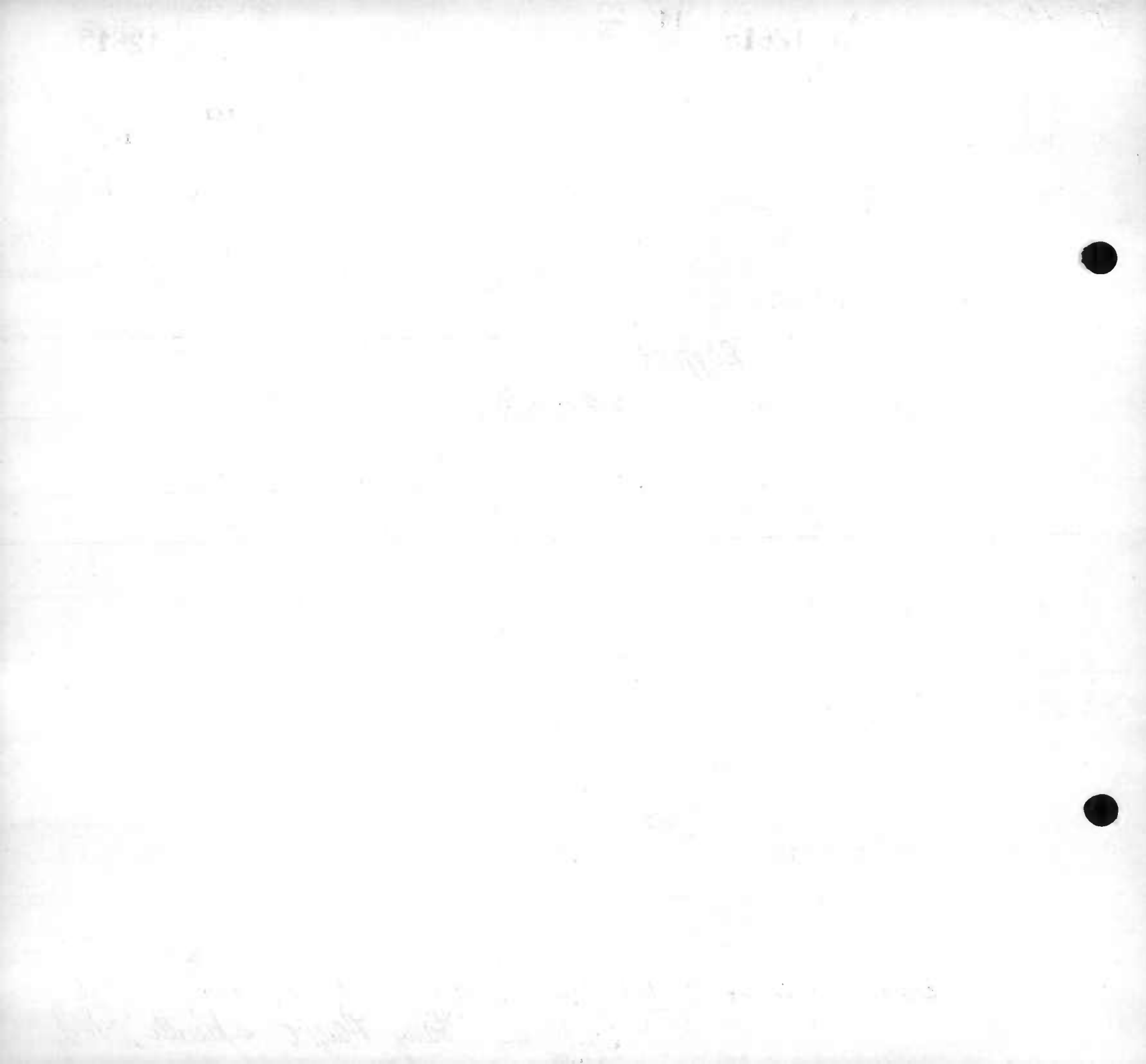
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10-10-10-10

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					REG. NO. <u>70 12615</u>				
BIRTH NO. <u>70 12615</u>					2. DATE AND HOUR OF DEATH <u>12-23-70 11:52 PM</u>				
1. NAME OF DECEASED (Type or Print) <u>DORAN BUPPERT</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Howard</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					C. CITY OR TOWN <u>MARRIOTTSVILLE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>43 SOUTH BALTIMORE GEN. HOSP.</u>					E. STREET AND NUMBER <u>RIDGE ROAD</u>				
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-10-12</u>	9. AGE (In years last birthday) <u>60</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TIME KEEPER</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>BETHLEHEM STEEL</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>IRVIN Buppert</u>			14. MOTHER'S MAIDEN NAME <u>ROSEMARY BLAIRE</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>212 079134</u>		17. INFORMANT <u>HELEN - WIFE</u>		ADDRESS		
1B. <u>4/10/91</u> CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE <u>Pulmonary embolism acute</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>12-10-70</u> to <u>12-23-70</u> , that (I) (we) lost saw the deceased alive on <u>12-23-70</u> and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Lilia B. Villafania M.D.</u>					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12-23-70</u>		
23C. PHYSICIAN'S NAME (Type) <u>LILIA B. VILLAFANIA</u>					23D. ADDRESS <u>South Balto. Gen. Hosp.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-26-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Olive Cemetery</u>		24D. LOCATION (City, town, or county) <u>Sandalltown Md.</u>		(State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Harry Haight</u>		25C. FUNERAL DIRECTOR <u>Lysiville, Md.</u>		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

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M 4201

70 12616

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 12616

BIRTH NO.		1. NAME OF DECEASED <b>HARRIET E. MILES</b> (Type or Print)		2. DATE AND HOUR OF DEATH <b>12/24/70 12:50 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>University Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>University Hospital</b>				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>864 Lombard St.</b>					
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-8-88</b>	9. AGE (In years last birthday) <b>82</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US</b>					
13. FATHER'S NAME <b>Columbus O. Brown</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Phillips?</b>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-30-4982</b>		17. INFORMANT <b>Mrs. Theodore Mattheiss</b>	
18. <b>410.91</b> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Probable Acute myocardial infarction</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>12-28-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Henry A. Bruehl MD</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Henry Alison Bruehl MD</b>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-28-1970</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Howard Chapel Cemetery</b>	
24D. LOCATION <b>Howard County, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor MD</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>	
				ADDRESS <b>4107 Wilkens Ave. 21229</b>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B6221

70 12617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

70 12617

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BARAKAGA, James G.

2. DATE AND HOUR OF DEATH

December 21, 1970 2:30 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Veterans Administration Hospital  
3900 Loch Raven Blvd  
Baltimore, Maryland 21218

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE  
Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

5107 Eastern Avenue

5. SEX

Male

6. RACE

White

7. MARRIED ☐

NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

9-18-18

9. AGE (in years  
last birthday)

52

10. Under 1 Yr.  
Months Days

11. Under 24 Hrs.  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Production Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Unknown

11. BIRTHPLACE (State or foreign country)

Ohio

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Barakaga

14. MOTHER'S MAIDEN NAME

Mary Michi

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

1-15-43 to 10-19-45

16. SOCIAL  
SECURITY NO.

212-07-7055

17. INFORMANT

Records

ADDRESS

VAH, 3900 Loch Raven Blvd. balto., Md. 21218

18. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

Brain tumor

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 year

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

10/30/70

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

unexplained rt  
cranial nerve pulses

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21E. INJURY OCCURRED

While At  
Work ☐

Not While  
At Work ☐

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from October 13, 1970 to December 21, 1970  
that (1) (we) last saw the deceased alive on December 21, 1970 and that in (1) (my) (our) opinion death occurred on the date  
and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

*Jack I Stern*

Attending  
Phys. ☐

Med.  
Director ☐

Staff  
Phys. ☒

23B. DATE SIGNED

12/22/70

23C. PHYSICIAN'S  
NAME (Type)

JACK I STERN, M.D.

23D. ADDRESS

3900 Loch Raven Blvd Balto., Md. 21218

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12-24-70

24C. NAME of CEMETERY or CREMATORY

Green Orthodox Cem

24D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 30 1970

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Matthews Funeral Home

ADDRESS

3021 Eastern Ave.  
Baltimore, Md.

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70 12618

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12618

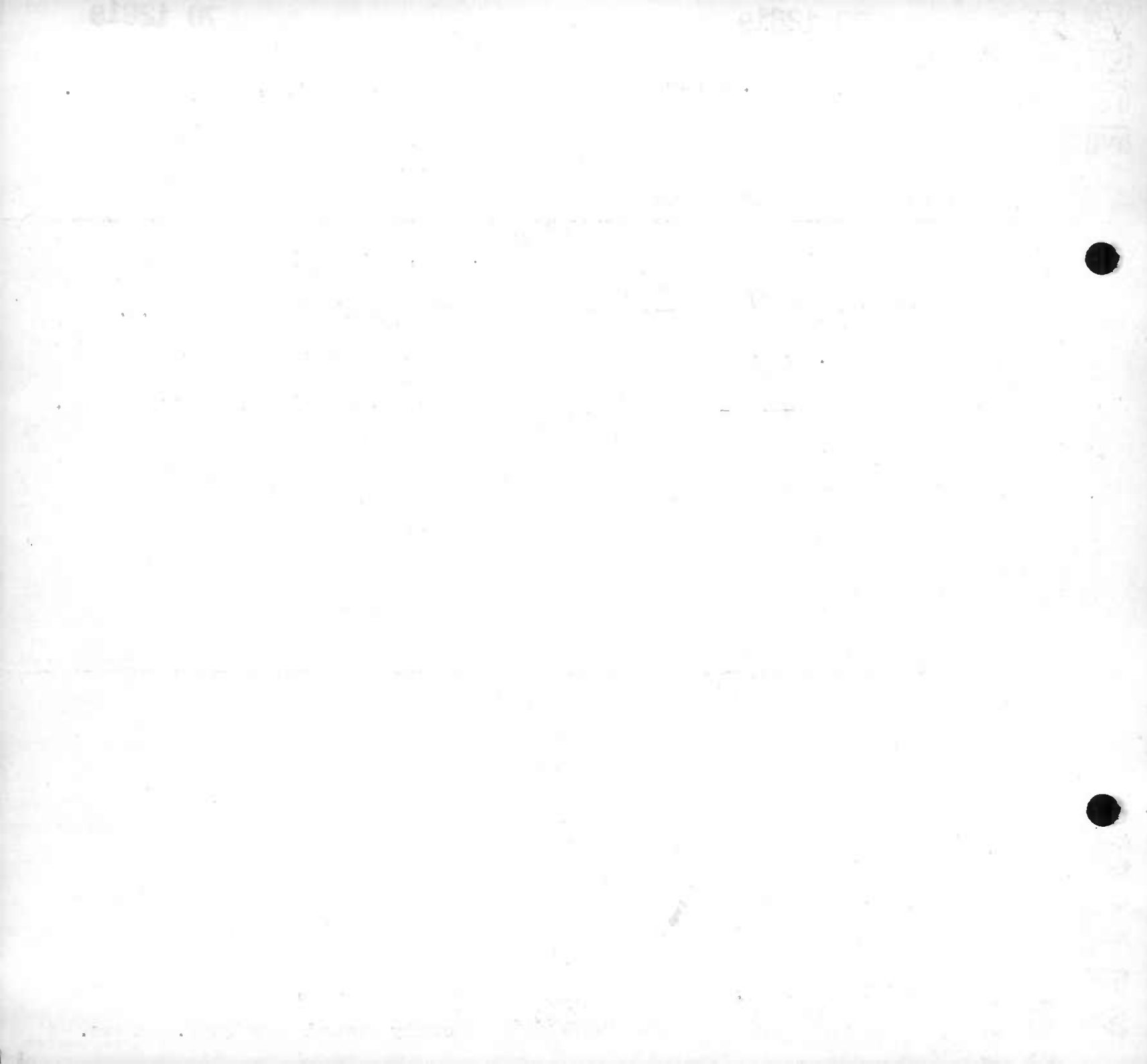
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>L. JOSEPH MC CARTHY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Agnes Hospital (DVA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 24 1970 8:40 p.m.</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2531</b>	
6. SEX <b>male</b>	7. RACE <b>white</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>June 1, 1938</b>		10. AGE (In years lost birthday) <b>32</b>	11. BIRTHPLACE (State or foreign country) <b>New York</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Lawrence McCarthy</b>		E. STREET AND NUMBER <b>4905 Williston St.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Margaret Martin</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1956 - 1959</b>		17. SOCIAL SECURITY NO. <b>050-30-3553</b>		18. INFORMANT <b>Mrs. Nancy L. McCarthy, 4905 Williston St.</b>	
19. <b>3039 I</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Acute ethylism</b> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<b>Arteriosclerotic cardiovascular disease</b>			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12-25-70</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-29-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Peters &amp; St. Pauls Cem.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Talley, M.D.</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>	
24D. LOCATION (City, town, or county) (State) <b>Chemung County, New York</b>					

Letter from M.E.'s office

2-16-71 M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12619	
1. NAME OF DECEASED (Type or Print) <b>Robert C. Varner</b>			2. DATE AND HOUR OF DEATH <b>December 25, 1970 11 A. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 3604 10th Street</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3604 10th Street</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 14, 1905</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Furniture Finisher</b>			11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John F. Varner</b>			14. MOTHER'S MAIDEN NAME <b>Idella Chamilton</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>unknown</b>		
17. INFORMANT <b>Frances Brewer</b>			ADDRESS <b>3604 10th Street Balto.</b>		
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Coronary Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. DATE OF OPERATION <b>0</b>			20A. AUTOPSY? (Yes or No) <b>No</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>7/17</b> <b>1963</b> to <b>25 Dec 70</b> <b>19</b> , that (I) (we) last saw the deceased alive on <b>12/16/1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Andrew R. Sosnowski</b>			23B. DATE SIGNED <b>12/25/70</b>		
23C. PHYSICIAN'S NAME (Type) <b>Andrew R. Sosnowski</b>			23D. ADDRESS <b>4016 Ritchie Hwy Balto. 25 Md</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/28/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loyjoy Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Troy, North Carolina</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>McCully Funeral Home 130 E. Fort Ave.</b>			



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## BALTIMORE CITY HEALTH DEPARTMENT

## 70 12620 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12620

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Frank W. Reynolds

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

## 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

## 5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)

## A. STATE

Maryland

## B. COUNTY

Baltimore

## C. CITY OR TOWN

Baltimore

## D. INSIDE CITY LIMITS?

YES ☒NO ☐

## 6. SEX

male

## 7. RACE

white

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

## 9. DATE OF BIRTH

Aug. 2, 1881

10. AGE (In years  
last birthday)

89

11. Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

## 11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF  
WHAT COUNTRY?

USA

## 13. FATHER'S NAME

William Owens Reynolds

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Storekeeper - B&amp;O RR

## 14B. KIND OF BUSINESS OR INDUSTRY

## 15. MOTHER'S MAIDEN NAME

Fannie Calihan

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL  
SECURITY NO.

## 18. INFORMANT

## ADDRESS

Bess Tatman -2163 A Via Mara Posa

## 19.

412.41

## CAUSE OF DEATH

Laguna Hills East, Calif. 92653

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

## (A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## (B)

DUE TO, OR AS A CONSEQUENCE OF:

## (C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

## 20A. DATE OF OPERATION

## 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

## 21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

## 22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

## 22F. HOW DID INJURY OCCUR?

## 23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

Deputy Chief Medical Examiner

DATE SIGNED

12/26/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

## 24B. DATE

12-31-70

## 24C. NAME OF CEMETERY or CREMATORY

Memorial Burial Park

## 24D. LOCATION (City, town, or county)

Wheelersburg

## (State)

Ohio

## 25A. DATE REC'D BY HEALTH DEPT.

## 25B. NAME OF REGISTRAR

## 25C. FUNERAL DIRECTOR

## ADDRESS

DEC 30 1970

Robert E. Taylor, M.D.

12 9 6 0

Armocost Funeral Chapel-4600 Liberty Hts



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

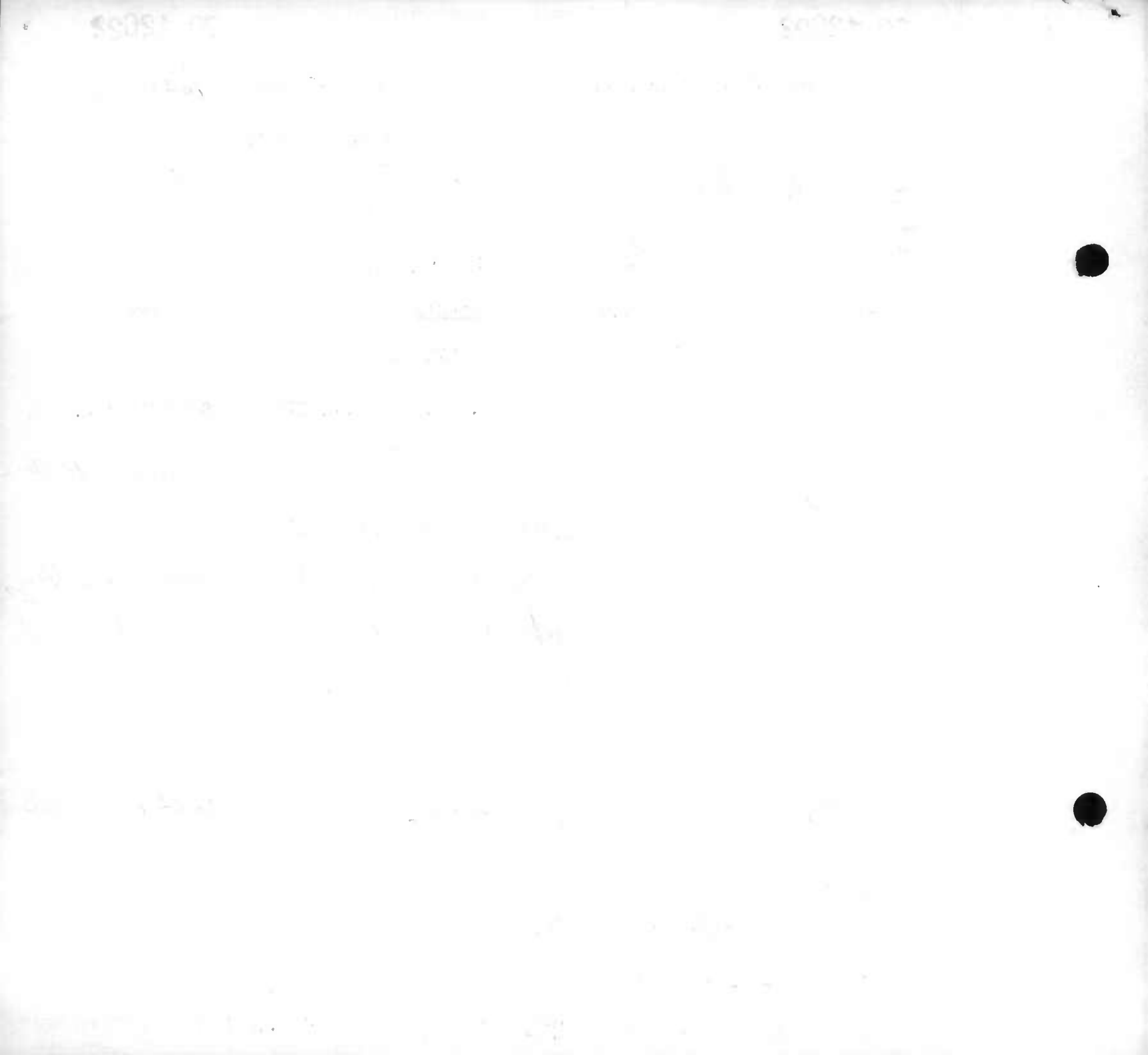
70 12621 HACK		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 12621	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Bessie Hack</u>		2. DATE AND HOUR OF DEATH <u>12-25-70</u> <u>2:05 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2719</u>		C. CITY OR TOWN <u>Bethesda</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Leatherman Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>4001 W. NORTHERN PKWY., APT. C1</u>	
5. SEX <u>Female</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-1-83</u>	9. AGE (In years last birthday) <u>87</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>LATVIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>ABRAHAM SWIDGALL</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-32-2151A</u>		17. INFORMANT ADDRESS <u>MRS. MAE SHAPOS, 4001 W. NORTHERN PKWY., APT. C1</u>	
18. <u>03891</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>SEPTICAEMIA WITH PNEUMONIA</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) showing the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>12-25-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/20/1970</u> to <u>12/25/1970</u> that (I) (we) last saw the deceased alive on <u>12/25/1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>S. Basu</u>		23B. DATE SIGNED <u>12/25/70</u>		23C. PHYSICIAN'S NAME (Type) <u>S. BASU</u>	
23D. ADDRESS <u>Leatherman Hospital of Maryland</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-27-70</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>WORKMEN CIRCLE</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1970</u>	
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>		25D. ADDRESS	

10341 67



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 12622</b>	
70 12622					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>ALBERT - WIENNER</b>			2. DATE AND HOUR OF DEATH <b>12/26/40 10:09 AM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2719</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Inai hospital</b>			C. CITY OR TOWN <b>Balto</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>2704 SULGRAVE AVENUE</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 15, 1911</b>	9. AGE (In years last birthday) <b>29</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GOURMET STORE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>OWNER</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>YESX YETTA ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>DR. ERIC BELGRAD, 2704 SULGRAVE AVE. #15</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>4/2/31</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>arrhythmic - cardiogenic shock</b> (B) <b>CHF - ASCVD - MI</b> (C) <b>Metabolic acidosis: elect imbalance 3-7 days</b> <b>1-2 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 hours</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>1-2 days</b>		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLINO OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/26</b> 19 <b>40</b> to <b>12/26</b> 19 <b>40</b> that (I) (we) last saw the deceased alive on <b>12/26</b> 19 <b>40</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>R. Hoozgar 9:08 AM</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>HOOZGAR, M.D.</b>				23D. ADDRESS <b>Bnai hospital Balto. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-28-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MOSES MONTIFIORE</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson, M.D.</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

55361

70 12623

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 12623

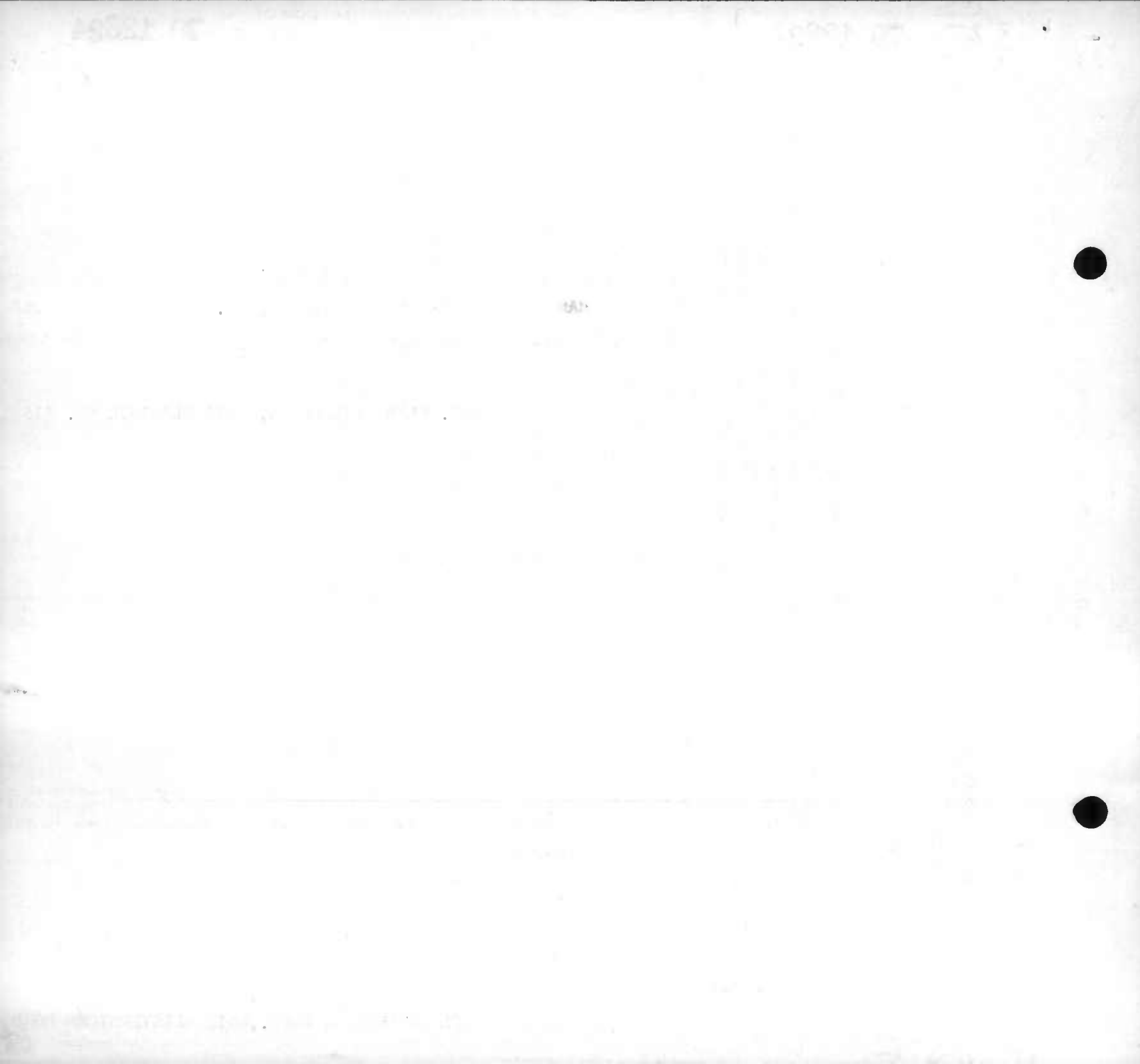
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <i>Snider, Louis</i>		2. DATE AND HOUR OF DEATH <i>27 Dec 70 12 45 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Levinthal Hebrew Home &amp; Infirmary</i>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>5500 NOME AVENUE</i>	
5. SEX <i>Male</i>	6. RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>XXXXXX</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PROPRIETOR</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>SHOE REPAIR</i>	9. AGE (In years last birthday) <i>78</i> 11. BIRTHPLACE (State or foreign country) <i>RUSSIA</i>
13. FATHER'S NAME <i>? SNIDER</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>218-32-4991</i>	
17. INFORMANT <i>MRS. GERTRUDE SAKOLSKY, 6506 HAL COURT #21209</i>		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Metastatic Prostatic Carcinoma</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <i>12-28-70</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>PROSTATECTOMY</i> 20A. AUTOPSY? (Yes or No) <i>NO</i> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>NO</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <i>HOME</i>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>(Month) (Day) (Year) (Hour)</i>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <i>4 Nov</i> 19 <i>68</i> to <i>27 Dec</i> 19 <i>70</i> that (we) last saw the deceased alive on <i>27 Dec</i> 19 <i>70</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.			
23A. SIGNATURE <i>Morris Octroff, M.D.</i>		23B. DATE SIGNED <i>27 Dec 70</i>	
23C. PHYSICIAN'S NAME (Type) <i>Morris Octroff, M.D.</i>		23D. ADDRESS <i>Levinthal Hebrew Home &amp; Infirmary</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>12-28-70</i>	24C. NAME OF CEMETERY OR CREMATORY <i>AHAVASH SHALOM</i>	24D. LOCATION (City, town, or county) (State) <i>ROSEDALE, MARYLAND</i>
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 30 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, R.D.</i>	
25C. FUNERAL DIRECTOR <i>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</i>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 12624</b>	
BIRTH NO. <b>70 12624</b>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>DANIEL WALDERMAN</b>			2. DATE AND HOUR OF DEATH <b>12/24/70 10:30 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>Union Memorial Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2720</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Union Memorial Hospital</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>3913 Clarinth Road</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>01/18/21</b>	9. AGE (In years last birthday) <b>49</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office Worker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>STATE OF Md.</b>		11. BIRTHPLACE (State or foreign country) <b>XXXXXX BALTIMORE, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>American USA</b>			13. FATHER'S NAME <b>Paul Waldeman</b>		
14. MOTHER'S MAIDEN NAME <b>Clara Raphael</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>MRS. CLARA WALDERMAN, 3913 CLARINTH RD. #15</b>		
18. <b>431.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Respiratory and cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Cerebral hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>II</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/23</b> 19 <b>70</b> to <b>12/24</b> 19 <b>70</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/24</b> 19 <b>70</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Khoury</b>			23B. DATE SIGNED <b>12/24/70</b>		
23C. PHYSICIAN'S NAME (Type) <b>JACQUES KHOURY</b>			23D. ADDRESS <b>Union Memorial Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-27-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>WORKMAN CIRCLE</b>	
24D. LOCATION <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			



70 12625

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 12625

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Elizabeth Anne Bakutis		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour	M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Bolton Hill Nursing Home		3. DATE PRONOUNCED DEAD		Month	Day	Year	Hour	M.
				12	24	70	6:10 p	M.
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1803								
6. SEX female	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
9. DATE OF BIRTH 4-23-1887	10. AGE (In years lost birthday) 83	11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? XXX		13. FATHER'S NAME Gasparas Publiackas		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		14B. KIND OF BUSINESS OR INDUSTRY Tailoring		15. MOTHER'S MAIDEN NAME				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 217 01 5021A		18. INFORMANT Mrs Agnes Owens		ADDRESS 6138 Parkway Dr		
19. 41247-5768X		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Terminal Pneumonia DUE TO, OR AS A CONSEQUENCE OF:						
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF:						
		(C)						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Fracture of left hip						
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no				
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? unit block of Fremont Ave. 1803				
22D. TIME OF INJURY (APPROX.) 10 16 70 4:35 Pm.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? assault and purse snatching				
23.		I certify that I held an Inquiry <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-28-70		24C. NAME OF CEMETERY or CREMATORY Most Holy Redeemer Co		24D. LOCATION (City, town, or county) (State) Balto Md		
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Thomas J. Kerry Inc		ADDRESS 1600 Hollins St		

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70 12626 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 12626

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charles C Grams		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 27 70 3:30 a.m.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Sept. 13, 1923		10. AGE (in years lost birthday) 47	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		14B. KIND OF BUSINESS OR INDUSTRY Tank Truck	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes # 2		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME Charles F. Grams		15. MOTHER'S MAIDEN NAME Catherine Rehmert	
18. INFORMANT Wm. B. Grams		ADDRESS 1447 Patapsco St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 12 24 70 12:54 p.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Druid Pk. Dr. and Chipper Ave. 1338		22F. HOW DID INJURY OCCUR? passenger in truck which struck pole	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 12/27/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12 30 70	
24C. NAME OF CEMETERY OR CREMATORY Cathedral		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Mc Cully		ADDRESS 130 E. Fort Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 12627		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12627	
1. NAME OF DECEASED (Type or Print) <b>KATHERINE E. WILLIAMS</b>			2. DATE AND HOUR OF DEATH <b>12-26-70 12:30 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>South Baltimore Memorial Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2402</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Baltimore Memorial Hospital</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>F</b>			6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>At. Home</b>		8. DATE OF BIRTH <b>2-16-94</b> AGE On years last birthday <b>76 yrs.</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Charles W. Higgs</b>			14. MOTHER'S MAIDEN NAME <b>Bernice Penn</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>James Williams (HUSBAND) SAME</b>
18. <b>412.2</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH !This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiopulmonary arrest</b> (B) <b>Hypertensive Anterior wall Myocardial Infarction</b> (C) <b>Intractable Cardiac Arrhythmia</b>		
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>12-23</b> 19 <b>70</b> to <b>12-26</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>12-26-70 12:30 P.M.</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Virginia F. Mercado, M.D.</b>			23B. DATE SIGNED <b>12-26-70</b>		23C. PHYSICIAN'S NAME (Type) <b>VIRGINIA F. MERCADO, M.D.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>12 30 70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Cross</b>
24D. LOCATION <b>Brooklyn, A. A. Co. Md.</b>			25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>		
25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>			25C. FUNERAL DIRECTOR <b>W. C. Taylor, Jr.</b>		

1909

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>70 12628</b>	
BIRTH NO. <b>70 12628</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>CHARLES E. MARTIN</b>		2. DATE AND HOUR OF DEATH <b>12/25/70 11 14 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 Union Memorial Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>904</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>728 EXETER HALL AVE.</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 27, 1901</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>BRABER'S DEPT. STORE</b>	9. AGE (In years last birthday) <b>69</b>
13. FATHER'S NAME <b>CHARLES MARTIN</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
16. SOCIAL SECURITY NO. <b>215-10-3068</b>		14. MOTHER'S MAIDEN NAME <b>MOLLIE SKIPPER</b>	
17. INFORMANT <b>MRS. ANNA M. MARTIN</b>		ADDRESS <b>(SAME)</b>	
18. CAUSE OF DEATH <b>456X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia with Septicemia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>NO</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>12/23</b> 19 <b>70</b> to <b>12/25</b> 19 <b>70</b> that (I) <del>(we)</del> last saw the deceased alive on <b>12/25</b> 19 <b>70</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> <del>(did not)</del> view the body after death.			
23A. SIGNATURE <b>H. Earl Cotman, M.D.</b>		23B. DATE SIGNED <b>12/26/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>H. Earl Cotman, M.D.</b>		23D. ADDRESS <b>Union Memorial Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>12-29-70</b>	24C. NAME OF CEMETERY <b>MORELAND MEMORIAL PK.</b>	24D. LOCATION (City, town, or county) (State) <b>BALTO., MD.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>	25B. NAME OF REGISTRAR <b>Robert E. Fisher, R.D.</b>	25C. FUNERAL DIRECTOR <b>J. Walter Conklin</b> ADDRESS <b>5444 BELAIR RD.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S 530 1

CERTIFICATE OF DEATH

REG. NO. 70 12629

BIRTH NO. 70 12629

1. NAME OF DECEASED  
(Type or Print)

EDNA M SMITH

2. DATE AND HOUR OF DEATH

12/23/70

2:05 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY 2008

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

129 S Collins Ave 21229

5. SEX

F

6. RACE

W

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

10-12-13

9. AGE (in years  
last birthday)

57

11 Under 1 Yr.

1 Yr. 1 Mo.

11 Under 24 Hrs.

24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Switchboard operator - State

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ind.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William H. Keast

14. MOTHER'S MAIDEN NAME

Mary Shmelz

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

213-30-9959

17. INFORMANT

son

ADDRESS

same as above

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Acute cerebral hemorrhage

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Hypertension

(C)

DUE TO, OR AS A CONSEQUENCE OF:

Exogenous Obesity

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

24 hours

many yrs.

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐

Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/22 1970 to 12/23 1970  
that (I) (we) last saw the deceased alive on 12/23 1970 and that (in my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Pratima Bose MD

Attending  
Phys. ☐

Med.  
Director ☐

Staff  
Phys. ☒

23B. DATE SIGNED

12/23/70

23C. PHYSICIAN'S  
NAME (Type)

PRATIMA BOSE MD

23D. ADDRESS

Mercy Hospital

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

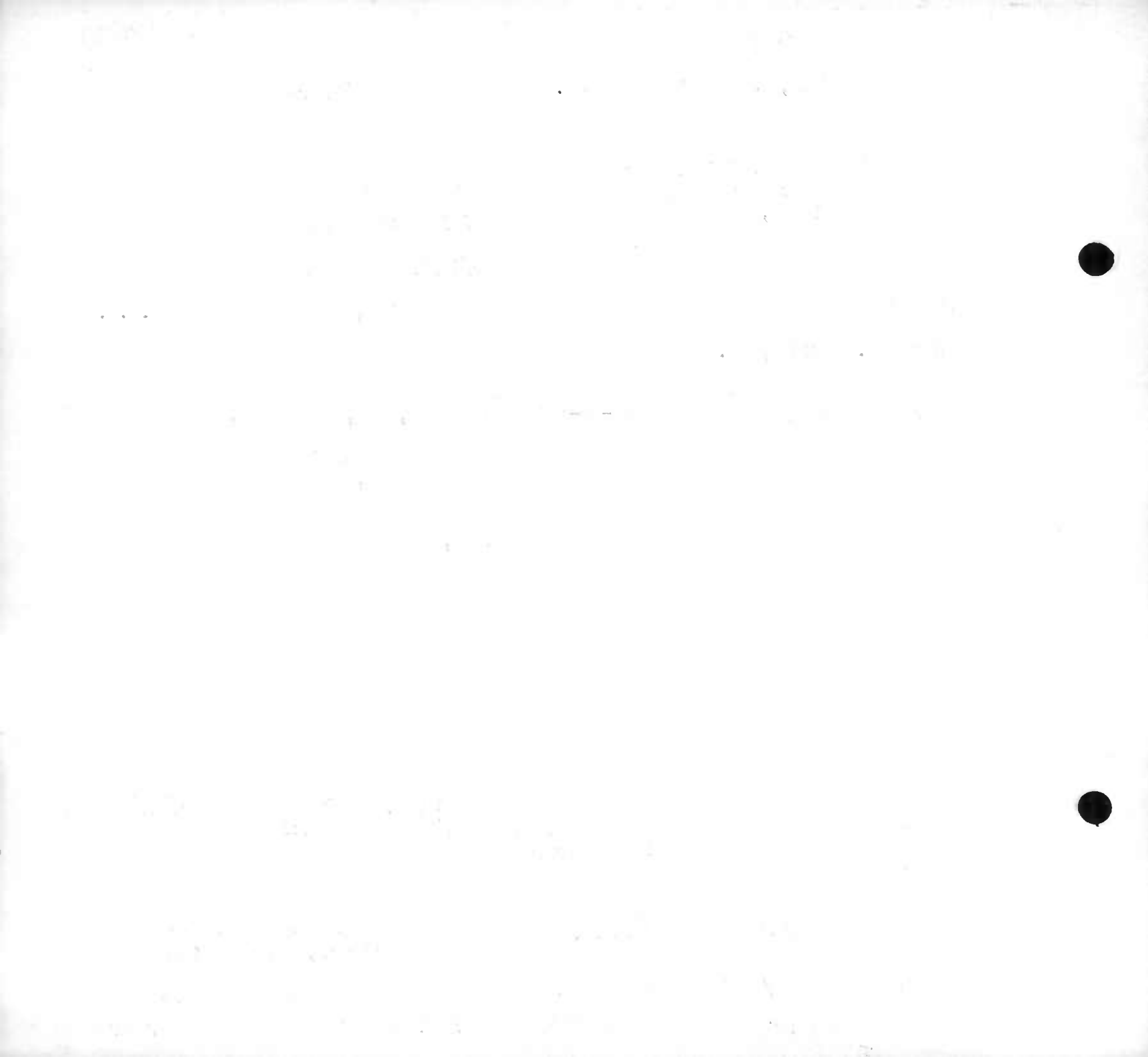


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## CERTIFICATE OF DEATH

REG. NO. 70 12630

BIRTH NO. 70 12630		1. NAME OF DECEASED (Type or Print) SELTZER, JAMES WILLIAM JR.		2. DATE AND HOUR OF DEATH 12/25/70	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Blvd Baltimore, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2737 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2433 Perrin Manor		
5. SEX MALE	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/14/13	9. AGE (in years lost birthday) 57	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10B. KIND OF BUSINESS OR INDUSTRY AUTOMOTIVE	11. BIRTHPLACE (State or foreign country) EMMETTSBURG, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JAMES W. SELTZER, SR.			14. MOTHER'S MAIDEN NAME MARGARET GRANT		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 216-05-6940	17. INFORMANT ADDRESS CLIN RECS, VAH, BALTIMORE, MARYLAND		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA (A) IMMEDIATE CAUSE BILATERAL, SEVERE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) ESOPHAGITIS, MODERATE DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 12/18/ 1970 to 12/25/ 1970 that (X) (we) last saw the deceased alive on 12/25/ 1970 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE Herbert I Gurley, M.D.				23B. DATE SIGNED 12/28/70	
23C. PHYSICIAN'S NAME (Type) HERBERT I GURLEY, M.D.		23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) burial	24B. DATE 12/29/70	24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore County, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR C. F. Evans & son 8802 Harford Road	



# FUNERAL DIRECTOR: IMPORTANT

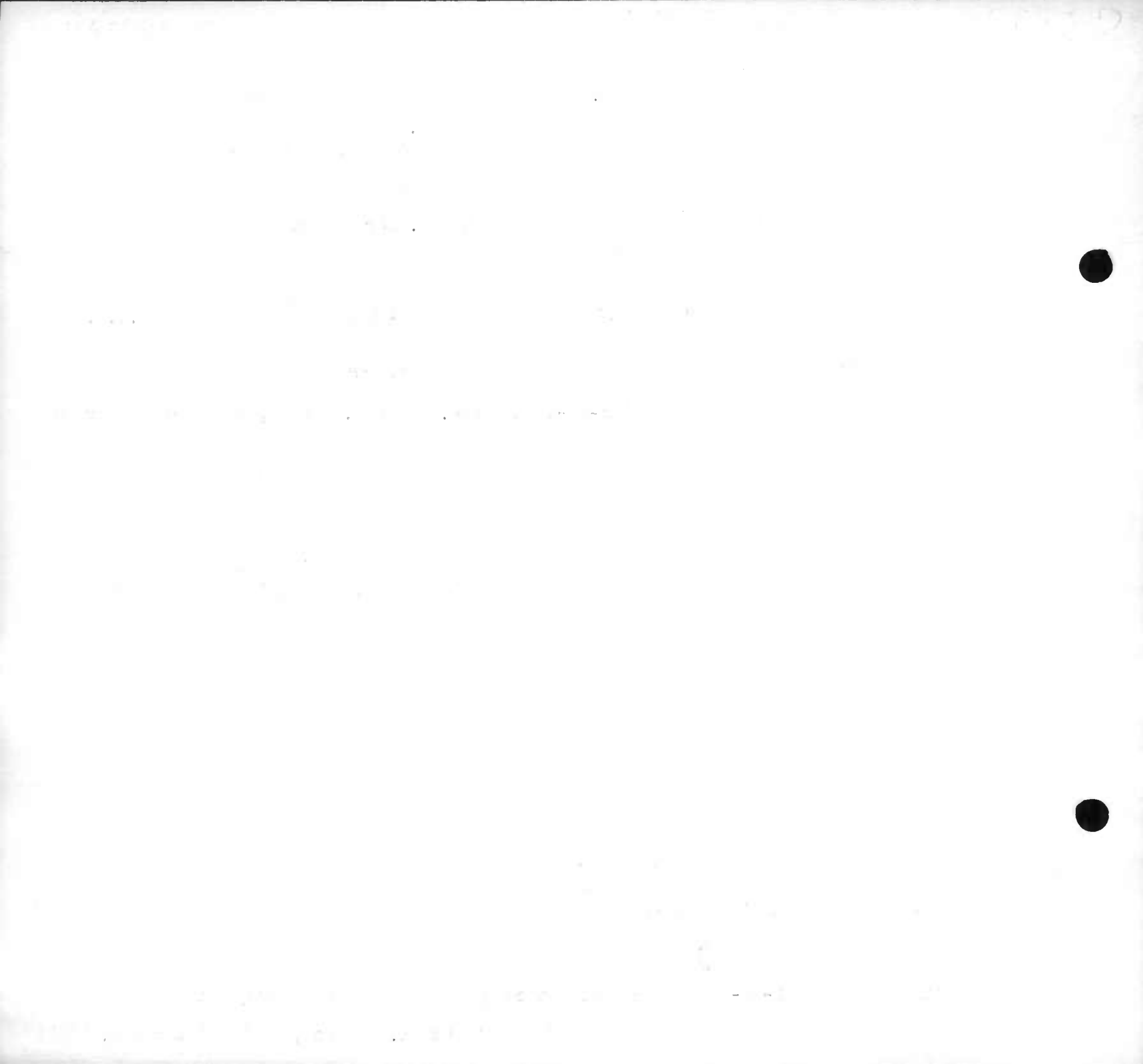
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>70 12631</b> <b>12631</b>
BIRTH NO. <b>70 12631</b>		1. NAME OF DECEASED (Type or Print) <b>LOUISE S. LEONARD</b>		
2. DATE AND HOUR OF DEATH <b>December 25, 1970 2:45 PM</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>90 Hood Nursing Home 5213 Edmondson Avenue</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> E. STREET AND NUMBER <b>4228 Eldone Drive</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-16-1893</b>	9. AGE (In years last birthday) <b>77</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Harry E. Jones</b>		
14. MOTHER'S MAIDEN NAME <b>Catherine H. Erbst</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>219-10-2598</b>		17. INFORMANT <b>Mr. Harry R. Leonard, 7918 Nottingham Way</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Thrombosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral Thrombosis as a result of Aortic Aneurysm</b>		
		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>NCU due to Diabetes</b>		
		(C) <b>1951</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>12/15</b> 19 <b>70</b> to <b>12/25</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>12/25</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>E. W. Johnson</b>		23B. DATE SIGNED <b>12/30/70</b>		
23C. PHYSICIAN'S NAME (Type) <b>E.W. Johnson</b>		23D. ADDRESS <b>3432 Frederick Avenue, Baltimore, Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-28-1970</b>		24C. NAME OF CEMETERY or CREMATORY <b>Western Cemetery</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
70 12632		CERTIFICATE OF DEATH		70 12632	
1. NAME OF DECEASED (Type or Print) <u>CHANEY William D.</u>		2. DATE AND HOUR OF DEATH <u>12/24/70</u> <u>5:15</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>XXXXXX</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BON SECOUR HOSP.</u>		C. CITY OR TOWN <u>BALTO. MD.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Coast Guard</u>		8. DATE OF BIRTH <u>5/3/00</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		9. AGE (In years lost birthday) <u>70</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-09-1451</u>		17. INFORMANT <u>Mrs. Nelva D. Chaney, 2503 Ashton Street</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>Coronary heart failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>myocardial disease</u> <u>diabetes mellitus</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		19. DATE OF OPERATION <u>0</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3:50 PM 12/24/1970</u> to <u>5:15 PM 12/24/1970</u> that (I) (we) last saw the deceased alive on <u>5:15 PM 12/24/1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W. E. Deaver MD</u>		23B. DATE SIGNED <u>12/24/70</u>		23C. PHYSICIAN'S NAME (Type) <u>W. E. Deaver MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-29-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25D. ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>70 12633</b>	
BIRTH NO. <b>70 12633</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED <b>DEUTSCH, Miss Louise</b>		2. DATE AND HOUR OF DEATH <b>12-25-1970 11 45 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Maryland Gen. Hospital</b>		A. STATE <b>Md.</b> B. COUNTY <b>City</b> <b>1101</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>524 N. Charles St Apt 510</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>N.M.</b>	8. DATE OF BIRTH <b>7/25/1893</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Union Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>John Deutsch</b>			
14. MOTHER'S MAIDEN NAME <b>Susan Deutsch</b>		*****			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-12-0808</b>		17. INFORMANT ADDRESS <b>Mrs. Dolores A. Taras 3111 Magnolia Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>412.4</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Indicerebral hemorrhage</b>		CAUSE OF DEATH <b>Indicerebral hemorrhage</b> (A) DUE TO <b>A.S.C.V.D.</b> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>yes</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-24-1970</b> to <b>12-25-1970</b> , that (I) (we) lost saw the deceased alive on <b>12-25-1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M S AL-IBRAHIM</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>M. S. AL-IBRAHIM</b>		23D. ADDRESS <b>Maryland Gen. Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/29/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION (City, town, or county) (State) <b>2106 4430 Belair Rd. Balto Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Chas Green M Cully</b>			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12634		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 12634	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MACKNOVITZ, ANNA		12-27-70 3:05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence, before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND			
SOUTH BALTIMORE GENERAL HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1603 CEREAL ST.			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-21-1898	9. AGE (in years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOHN LINDBERG		14. MOTHER'S MAIDEN NAME MATILDA VOLKMAN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-03-7166-A		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: METASTATIC CARCINOMA AETIOLOGY UNKNOWN. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE & ATRIAL FIBRILLATION.				4 years.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If only medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-24-1970 to 12-27-1970 that (I) (we) lost saw the deceased alive on 12-27-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hargit Singh MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-27-70	
23C. PHYSICIAN'S NAME (Type) HARJIT SINGH		23D. ADDRESS SOUTH BALTIMORE GENERAL HOSPITAL BALTIMORE MD 21201			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-30-70		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cem.	
24D. LOCATION Balt. 21225, Md.		24E. DATE REC'D BY HEALTH DEPT. DEC 30 1970		24F. NAME OF REGISTRAR Robert E. Taylor, Jr.	
24G. NAME OF REGISTRAR		24H. NAME OF REGISTRAR		24I. NAME OF REGISTRAR	
24J. NAME OF REGISTRAR		24K. NAME OF REGISTRAR		24L. NAME OF REGISTRAR	
24M. NAME OF REGISTRAR		24N. NAME OF REGISTRAR		24O. NAME OF REGISTRAR	
24P. NAME OF REGISTRAR		24Q. NAME OF REGISTRAR		24R. NAME OF REGISTRAR	
24S. NAME OF REGISTRAR		24T. NAME OF REGISTRAR		24U. NAME OF REGISTRAR	
24V. NAME OF REGISTRAR		24W. NAME OF REGISTRAR		24X. NAME OF REGISTRAR	
24Y. NAME OF REGISTRAR		24Z. NAME OF REGISTRAR		24AA. NAME OF REGISTRAR	
24AB. NAME OF REGISTRAR		24AC. NAME OF REGISTRAR		24AD. NAME OF REGISTRAR	
24AE. NAME OF REGISTRAR		24AF. NAME OF REGISTRAR		24AG. NAME OF REGISTRAR	
24AH. NAME OF REGISTRAR		24AI. NAME OF REGISTRAR		24AJ. NAME OF REGISTRAR	
24AK. NAME OF REGISTRAR		24AL. NAME OF REGISTRAR		24AM. NAME OF REGISTRAR	
24AN. NAME OF REGISTRAR		24AO. NAME OF REGISTRAR		24AP. NAME OF REGISTRAR	
24AQ. NAME OF REGISTRAR		24AR. NAME OF REGISTRAR		24AS. NAME OF REGISTRAR	
24AT. NAME OF REGISTRAR		24AU. NAME OF REGISTRAR		24AV. NAME OF REGISTRAR	
24AW. NAME OF REGISTRAR		24AX. NAME OF REGISTRAR		24AY. NAME OF REGISTRAR	
24AZ. NAME OF REGISTRAR		24BA. NAME OF REGISTRAR		24BB. NAME OF REGISTRAR	
24BC. NAME OF REGISTRAR		24BD. NAME OF REGISTRAR		24BE. NAME OF REGISTRAR	
24BF. NAME OF REGISTRAR		24BG. NAME OF REGISTRAR		24BH. NAME OF REGISTRAR	
24BI. NAME OF REGISTRAR		24BJ. NAME OF REGISTRAR		24BK. NAME OF REGISTRAR	
24BL. NAME OF REGISTRAR		24BM. NAME OF REGISTRAR		24BN. NAME OF REGISTRAR	
24BO. NAME OF REGISTRAR		24BP. NAME OF REGISTRAR		24BQ. NAME OF REGISTRAR	
24BR. NAME OF REGISTRAR		24BS. NAME OF REGISTRAR		24BT. NAME OF REGISTRAR	
24BU. NAME OF REGISTRAR		24BV. NAME OF REGISTRAR		24BW. NAME OF REGISTRAR	
24BX. NAME OF REGISTRAR		24BY. NAME OF REGISTRAR		24BZ. NAME OF REGISTRAR	
24CA. NAME OF REGISTRAR		24CB. NAME OF REGISTRAR		24CC. NAME OF REGISTRAR	
24CD. NAME OF REGISTRAR		24CE. NAME OF REGISTRAR		24CD. NAME OF REGISTRAR	
24CE. NAME OF REGISTRAR		24CF. NAME OF REGISTRAR		24CE. NAME OF REGISTRAR	
24CF. NAME OF REGISTRAR		24CG. NAME OF REGISTRAR		24CF. NAME OF REGISTRAR	
24CG. NAME OF REGISTRAR		24CH. NAME OF REGISTRAR		24CG. NAME OF REGISTRAR	
24CH. NAME OF REGISTRAR		24CI. NAME OF REGISTRAR		24CH. NAME OF REGISTRAR	
24CI. NAME OF REGISTRAR		24CJ. NAME OF REGISTRAR		24CI. NAME OF REGISTRAR	
24CJ. NAME OF REGISTRAR		24CK. NAME OF REGISTRAR		24CJ. NAME OF REGISTRAR	
24CK. NAME OF REGISTRAR		24CL. NAME OF REGISTRAR		24CK. NAME OF REGISTRAR	
24CL. NAME OF REGISTRAR		24CM. NAME OF REGISTRAR		24CL. NAME OF REGISTRAR	
24CM. NAME OF REGISTRAR		24CN. NAME OF REGISTRAR		24CM. NAME OF REGISTRAR	
24CN. NAME OF REGISTRAR		24CO. NAME OF REGISTRAR		24CN. NAME OF REGISTRAR	
24CO. NAME OF REGISTRAR		24CP. NAME OF REGISTRAR		24CO. NAME OF REGISTRAR	
24CP. NAME OF REGISTRAR		24CQ. NAME OF REGISTRAR		24CP. NAME OF REGISTRAR	
24CQ. NAME OF REGISTRAR		24CR. NAME OF REGISTRAR		24CQ. NAME OF REGISTRAR	
24CR. NAME OF REGISTRAR		24CS. NAME OF REGISTRAR		24CR. NAME OF REGISTRAR	
24CS. NAME OF REGISTRAR		24CT. NAME OF REGISTRAR		24CS. NAME OF REGISTRAR	
24CT. NAME OF REGISTRAR		24CU. NAME OF REGISTRAR		24CT. NAME OF REGISTRAR	
24CU. NAME OF REGISTRAR		24CV. NAME OF REGISTRAR		24CU. NAME OF REGISTRAR	
24CV. NAME OF REGISTRAR		24CW. NAME OF REGISTRAR		24CV. NAME OF REGISTRAR	
24CW. NAME OF REGISTRAR		24CX. NAME OF REGISTRAR		24CW. NAME OF REGISTRAR	
24CX. NAME OF REGISTRAR		24CY. NAME OF REGISTRAR		24CX. NAME OF REGISTRAR	
24CY. NAME OF REGISTRAR		24CZ. NAME OF REGISTRAR		24CY. NAME OF REGISTRAR	
24CZ. NAME OF REGISTRAR		24DA. NAME OF REGISTRAR		24CZ. NAME OF REGISTRAR	
24DA. NAME OF REGISTRAR		24DB. NAME OF REGISTRAR		24DA. NAME OF REGISTRAR	
24DB. NAME OF REGISTRAR		24DC. NAME OF REGISTRAR		24DB. NAME OF REGISTRAR	
24DC. NAME OF REGISTRAR		24DD. NAME OF REGISTRAR		24DC. NAME OF REGISTRAR	
24DD. NAME OF REGISTRAR		24DE. NAME OF REGISTRAR		24DD. NAME OF REGISTRAR	
24DE. NAME OF REGISTRAR		24DE. NAME OF REGISTRAR		24DE. NAME OF REGISTRAR	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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70 12635

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 12635

BIRTH NO. 70 12635		2. DATE AND HOUR OF DEATH 12/25/70 7:10 A.M.	
1. NAME OF DECEASED (Type or Print) <b>INEZ BROOKS</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>BOLTON HILL NURSING HOME</b> <i>JOHNSI</i>	
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1502</b>		5. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. STREET AND NUMBER <b>No 09 Clapton St. 21217</b>		7. DATE OF BIRTH <b>9/30/91</b> 8. AGE (in years last birthday) <b>79</b>	
9. SEX <b>F</b> 10. RACE <b>N.</b>		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		13. KIND OF BUSINESS OR INDUSTRY	
14. FATHER'S NAME <b>EDDY ALEXANDER</b>		15. MOTHER'S MAIDEN NAME <b>CATHERINE ?</b>	
16. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>213-01-4101</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <b>12-24-70</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		19. INFORMANT <b>BOLTON HILL NURSING HOME</b> ADDRESS <b>1400 John St</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-24-70</b> to <b>12-25-70</b> and that (I) (we) last saw the deceased alive on <b>12/25</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Astoracion B. Paulino M.D.</i>		23B. DATE SIGNED <b>12/25/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Astoracion B. Paulino M.D.</b>		23D. ADDRESS <b>410 Medical Arts Bldg. Balt. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/29/70</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>		24D. LOCATION <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor M.D.</b>	
25C. FUNERAL DIRECTOR <b>A.S. Phillips</b>		25D. ADDRESS <b>1725 W. Monroe St.</b>	



70 12636

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 12636

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) ROBERT WISE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1841 W. Fayette St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 22 1970 10:30 P.M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2001	
9. DATE OF BIRTH 6/17/17		10. AGE (in years lost birthday) 47	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Wise		14. STREET AND NUMBER 1841 W. Fayette St.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sparrows Point		14B. KIND OF BUSINESS OR INDUSTRY Sparrows Point	
15. MOTHER'S MAIDEN NAME Ella ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Bertina Wise	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive & arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/29/70	
24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1970		25B. NAME OF REGISTRAR Robert E. Fabel, M.D.	
25C. FUNERAL DIRECTOR Arlington S. Phillips		ADDRESS 1727 North Monroe St	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12637		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 12637	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		William Scheu		12/29/70	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence, before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  829 Glen Allen Drive				A. STATE Md	
				B. COUNTY	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 829 Glen Allen Drive	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/27/06	9. AGE (In years last birthday) 64
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Burnham Eng. Co		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME John Thomas Scheu	
14. MOTHER'S MAIDEN NAME Matilida Pfeiffer Scheu				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown	
16. SOCIAL SECURITY NO. 283-03-0851				17. INFORMANT Mrs. Elinor Scheu, 829 Glen Allen Drive	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  Cerebral Hemorrhage					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  ARTERIO-SCLEROTIC CARDIO VASCULAR Disease					
(B) DUE TO, OR AS A CONSEQUENCE OF:  1 YR +					
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 45 to 12/29 19 70 that (I) (we) last saw the deceased alive on 12/4 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas E. Roach M.D.				23B. DATE SIGNED 12/29/70	
23C. PHYSICIAN'S NAME (Type) Dr. Thomas Roach				23D. ADDRESS 5550 Baltimore National Pike	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/31/70		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1970		25B. NAME OF REGISTRAR Robert E. Jansen, M.D.		25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Ave., 21228	



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70 12638

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12638

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Lucille Ritz		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12 28 70 Hour 12:45 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month Day Year 12 28 70 Hour 12:45 p.m.	
6. SEX female		7. RACE white	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Feb. 4, 1914		10. AGE (in years lost birthday) 56	
11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Addie Lee	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT John Ritz		ADDRESS 6169 Regent Park Road	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 12 28 70 ? m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 6169 Regent Pk. Dr.		22F. HOW DID INJURY OCCUR? ingested overdose of barbiturates	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 12/29/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/31/70	
24C. NAME OF CEMETERY or CREMATORY Woodlawn		24D. LOCATION (City, town, or county) (State) Woodlawn Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Witzke, Inc		ADDRESS 1630 Edmondson Ave.	

NO. 12345

NO. 12345

DATE OF BIRTH

DATE OF DEATH

1900

PERSONAL DATA		FAMILY DATA		MARRIAGE DATA		DEATH DATA	
NAME	AGE	FATHER'S NAME	MOTHER'S NAME	DATE OF MARRIAGE	PLACE OF MARRIAGE	DATE OF DEATH	PLACE OF DEATH
JOHN DOE	25	JAMES DOE	MARY DOE	1900	NEW YORK	1900	NEW YORK
JANE DOE	22	JAMES DOE	MARY DOE	1900	NEW YORK	1900	NEW YORK
EDWARD DOE	20	JAMES DOE	MARY DOE	1900	NEW YORK	1900	NEW YORK
MARY DOE	18	JAMES DOE	MARY DOE	1900	NEW YORK	1900	NEW YORK
CHARLES DOE	15	JAMES DOE	MARY DOE	1900	NEW YORK	1900	NEW YORK
ELIZABETH DOE	12	JAMES DOE	MARY DOE	1900	NEW YORK	1900	NEW YORK
WILLIAM DOE	10	JAMES DOE	MARY DOE	1900	NEW YORK	1900	NEW YORK
ANNE DOE	8	JAMES DOE	MARY DOE	1900	NEW YORK	1900	NEW YORK
JOHN DOE	5	JAMES DOE	MARY DOE	1900	NEW YORK	1900	NEW YORK
MARY DOE	3	JAMES DOE	MARY DOE	1900	NEW YORK	1900	NEW YORK
EDWARD DOE	1	JAMES DOE	MARY DOE	1900	NEW YORK	1900	NEW YORK

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## BALTIMORE CITY HEALTH DEPARTMENT

70 12639

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 12639

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Virginia Einstein		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 28 Year 70 Hour 2:45 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month 12 Day 28 Year 70 Hour 2:45 a.m.	
6. SEX female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2864	
9. DATE OF BIRTH FEB 21 1911		10. AGE (In years last birthday) 59	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER		14B. KIND OF BUSINESS OR INDUSTRY ST WILLIAMS	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 214-22-0831	
18. INFORMANT EDWIN K EINHSTEIN SR.		ADDRESS 4504 Manordene Road	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/28/70			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE DEC 31, 1970	
24C. NAME OF CEMETERY or CREMATORY LOUDON PARK		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1970		25B. NAME OF REGISTRAR Robert E. Gable, M.D.	
25C. FUNERAL DIRECTOR WITZKE'S FUNERAL HM		ADDRESS 4101 EDMONDSON AVE	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 12640

BIRTH NO. 70 12640

1. NAME OF DECEASED (Type or Print) <b>GARY Mr James A</b>		2. DATE AND HOUR OF DEATH <b>12/29/70 1AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>34 Bon Secour Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>34 Bon Secour Hospital</b>		C. CITY OR TOWN <b>Balt. Md.</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>720 Kent Ave.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>01/02/15</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Martin Spaulging</b>	9. AGE (In years last birthday) <b>55</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James E Gary</b>		14. MOTHER'S MAIDEN NAME <b>Sank Georgia L.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-09-5257</b>	17. INFORMANT <b>Mrs. Rosella Gary, 720 Kent AVE, 21228</b>
18. <b>43691</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>(A) IMMEDIATE CAUSE</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>CVA</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Acute myocardial infarction - 1 day</b> <b>(C)</b> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>1 day</b>	
19A. DATE OF OPERATION <b>12-20-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>No</b>	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <b>At Work</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) <b>12-29-70</b>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from <b>12-20-70</b> to <b>12-29-70</b> and that (I) (we) lost saw the deceased alive on <b>12-29-70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Jantra Voraaralesa</b>		23B. DATE SIGNED <b>12-29-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>JANTRA VORARALESA</b>		23D. ADDRESS <b>BSH</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>21/31/70</b>	
24C. NAME of CEMETERY or CREMATORY <b>Lakeview Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>	
25C. FUNERAL DIRECTOR <b>Witzke, 1630 Edmondson Ave., 21228</b>		ADDRESS	

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## BALTIMORE CITY HEALTH DEPARTMENT

70 12641

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 12641

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Joseph Edward Horneman</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>12 27 70 11:55 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>44 Union Memorial Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 27 70 11:55 A.M.</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2745</b>	
6. SEX <b>male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <b>5/5/08</b>	10. AGE (In years last birthday) <b>62</b>	E. STREET AND NUMBER <b>6402 Rosemont Ave.</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Acct. Clerk</b>		13. FATHER'S NAME <b>Emil Horneman</b>	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Bertha Gunkel</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>214 01 6604</b>	
18. INFORMANT <b>John E. Horneman</b>		ADDRESS <b>2301 Pentland Dr.</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12/28/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/31/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>		ADDRESS <b>Balto. Md.</b>	

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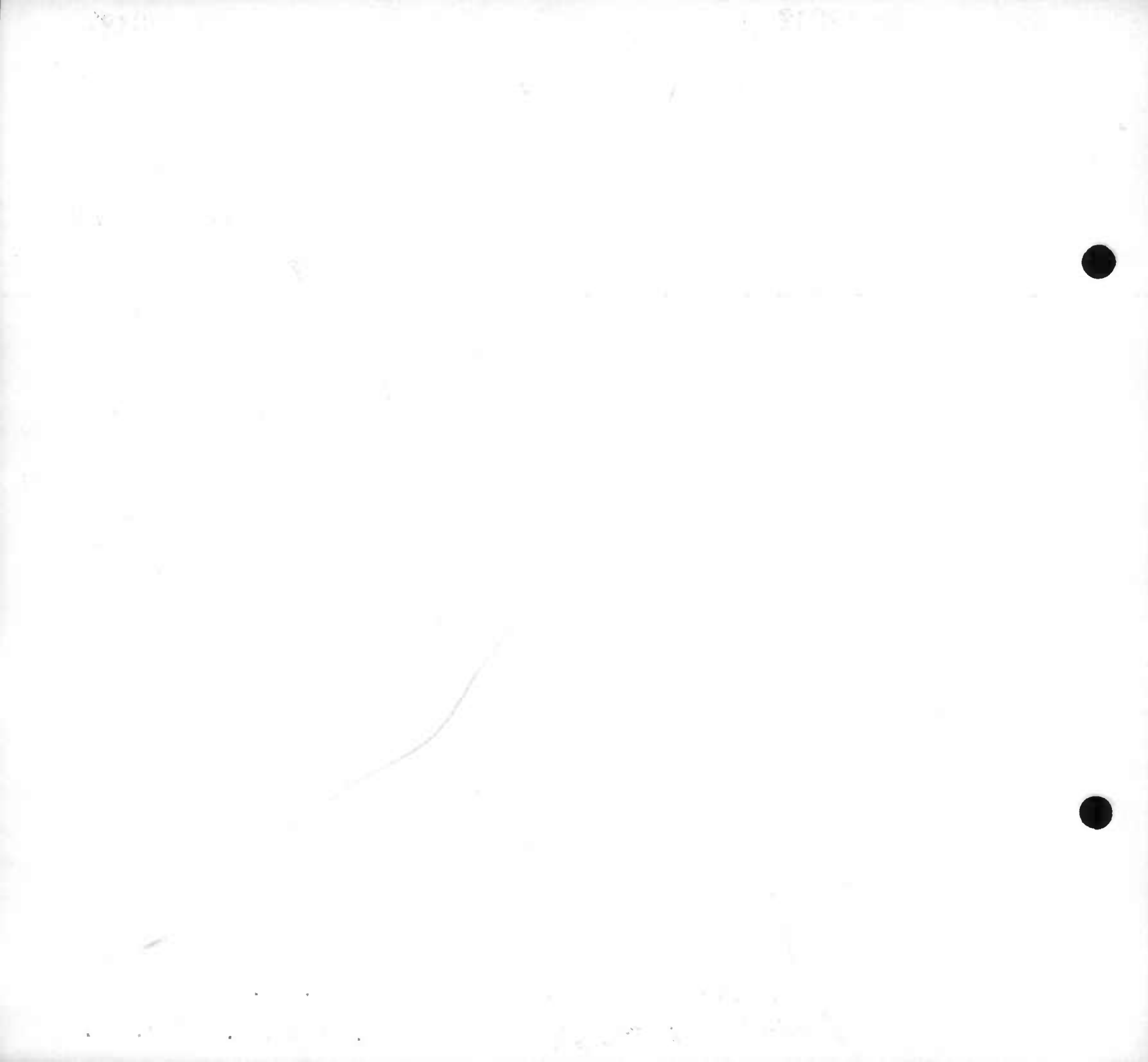
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

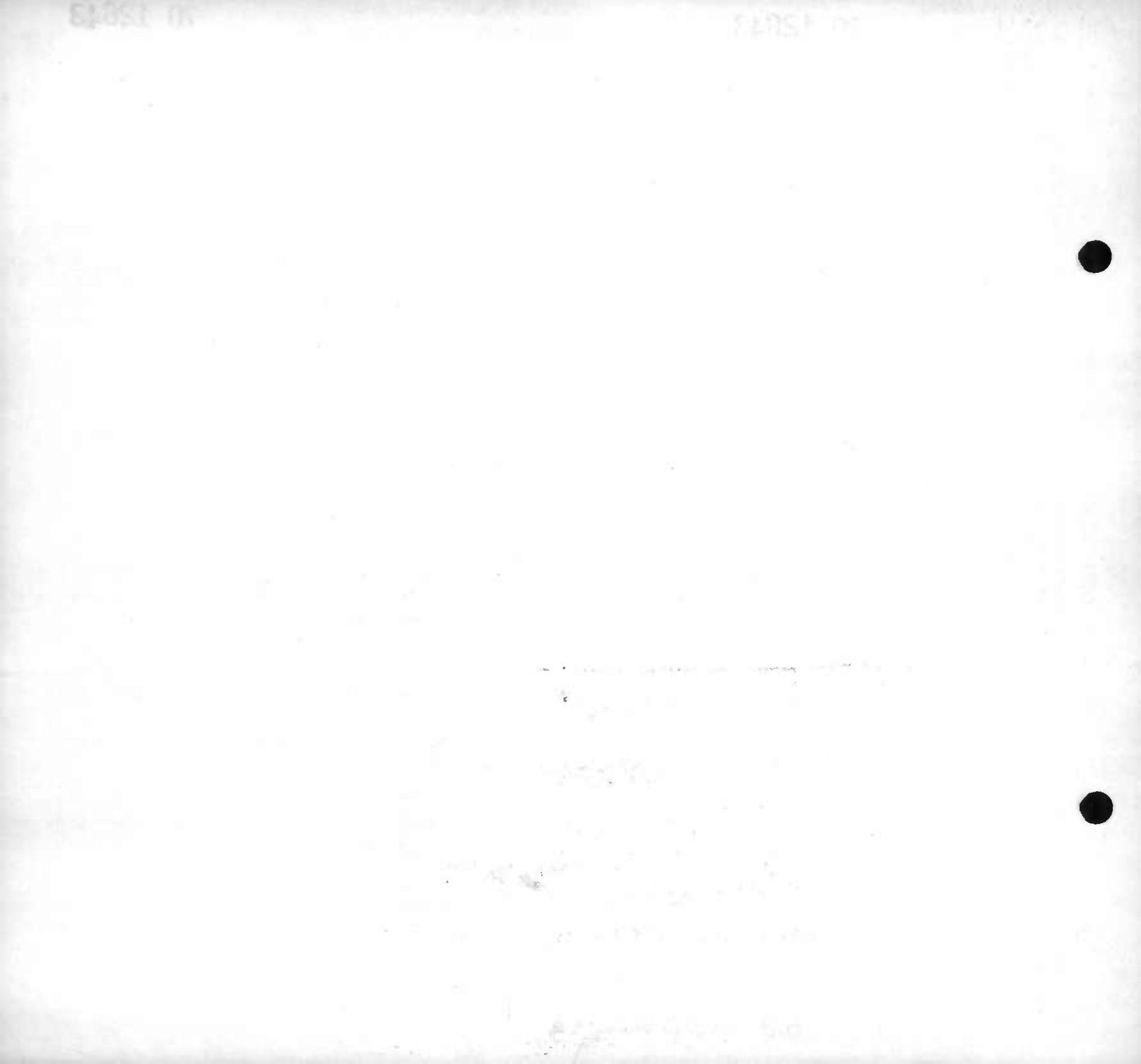
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>70 12642</b>
BIRTH NO. <b>70 12642</b>		1. NAME OF DECEASED <b>Catanese, <del>Charles</del> (Charles) Calogero</b>		
2. DATE AND HOUR OF DEATH <b>12/27/70 6:30 P.M.</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Montebello State Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) <b>Maryland - 902</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Montebello State Hospital</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>6/5/77</b>		9. AGE (In years last birthday) <b>93</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN</b>
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Jovanie Catanese</b>		14. MOTHER'S MAIDEN NAME <b>Angela SAVACA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>(Daughter) Katie Carlotta</b>
18. <b>410.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial infarction</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 minutes</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertensive arteriosclerotic cardiovascular disease</b>		<b>Many years</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Right middle cerebral artery thrombosis</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:		<b>7 yrs</b>
19A. DATE OF OPERATION <b>12/24/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <b>(1)</b> (this hospital) attended the deceased from <b>12/24/70</b> to <b>12/27/70</b> that <b>(1)</b> (we) last saw the deceased alive on <b>12/27/70</b> and that <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>W. Haddox SOTHORON</b>		23B. DATE SIGNED <b>12/27/70</b>		23C. PHYSICIAN'S NAME (Type) <b>W. Haddox SOTHORON</b>
23D. ADDRESS <b>Montebello State Hospital</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>12/30/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 70 12643		REGISTERED NO. 70 12643	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				MC NALLY, MAUDE		12/27/1970 7:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				MD. 1. 2631		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
48 Maryland General Hospital				Baltimore		D. STREET ADDRESS (If rural, give location)	
5708 Green Hill Ave.				5. SEX 6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
Female White				Widow.		8. DATE OF BIRTH 9. AGE (In years last birthday)	
9/6/1891. 79				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
none.				Govt. Employee		12. CITIZEN OF WHAT COUNTRY?	
U.S.A.				13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
NATHANIEL J. CROW				MARGARET F. PENTZ		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
NO NO				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
217038818				Mrs Edna Meekens.		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) DUE TO		52 hrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Myocardial Infarct in Embolus to bifurcation of aorta. Possible pulmonary embolus.			
II				(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
A. S. C. V. D.				19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
2				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
Yes.				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	
21F. HOW DID INJURY OCCUR?				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 12/28/1970 to 12/27/1970, that (I) (we) lost saw the deceased alive on 12/27/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE		23B. DATE SIGNED	
M. S. AL-IBRAHIM M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		12-27-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
M. S. AL-IBRAHIM M.D.				Maryland Gen. Hospital.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL				12-31-70		MORELAND MEMORIAL	
24D. LOCATION (City, town, or county) (State)				25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
BALTIMORE, MD.				DEC 30 1970 Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR ADDRESS	
LEONARD J. RUCK, Inc BALTO, MD.							



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12644		70 12644	
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
Charles Carroll Cooper		Dec. 21, 1970 1:45 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
00 410 Old Orchard Rd.		Ma. Balto. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX 6. RACE		E. STREET AND NUMBER	
Male White		410 Old Orchard Rd.	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9. AGE (In years lost birthday)	
Ret.		Dec. 18, 1897 73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Ret.		Balto.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Charles C. Cooper		Lavina Hoskins	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
no		17. INFORMANT ADDRESS	
no		410 Old Orchard Rd. Mrs. Myrtle E. Cooper	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		2 yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
0		no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
(APPROX.)		21E. INJURY OCCURRED	
While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the doctor) attended the deceased from April 19 49 to Dec. 19 70, that (I) (we) last saw the deceased alive on Dec. 12 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
Leo J. Gaver, M.D.		Dec. 21, 1970	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Leo J. Gaver, M.D.		1 Mallow Hill Rd., Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		12-23-1970	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
St. John's Cemetery		Ellicott City Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
DEC 30 1970		Robert E. Jolley, M.D.	
25C. FUNERAL DIRECTOR		25D. ADDRESS	
G. Truman Schwab		Balto. National Pike	



70 12645

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 12645

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JOseph Woodland

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐Month  
Day  
Year12  
23  
70Hour  
10:34 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

38

University Hospital

3. DATE  
PRONOUNCED DEADMonth  
Day  
Year12  
23  
70Hour  
10:34 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Md.

B. COUNTY

Charles

5800

C. CITY OR TOWN

Hughesville

D. INSIDE CITY LIMITS?

YES ☐NO ☒

6. SEX

male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

9. DATE OF BIRTH

11-27-1909

10. AGE (In years  
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Charles County, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Andrew Woodland

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mary M. Davis

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

216-12-4716

18. INFORMANT

ADDRESS

Mrs. Juanita Whalen-Charlotte Hall, Md.

19. E 819.1

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Hypertensive cerebral hemorrhage  
DUE TO, OR AS A CONSEQUENCE OF: complicating neck fracture

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Highway

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR? Md. St. 231 and intersection

Route 5

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.) 12 13 70 11:34  
a.m.22E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒22F. HOW DID INJURY OCCUR?  
Subject was a passenger in an auto  
accident.

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

12/23/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12-26-1970

24C. NAME of CEMETERY or CREMATORY

St. Mary Ch. Cem.

24D. LOCATION (City, town, or county) (State)

Bryantown, Chas. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 30 1970

25B. NAME OF REGISTRAR

Robert E. Talley, Jr.

25C. FUNERAL DIRECTOR

Martell Adams

ADDRESS

Agasson, Md.



70 12648

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 12648

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Curtis Cradler</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>12</b> Day <b>22</b> Year <b>70</b> Hour <b>3:01</b> P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>38 University Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>12</b> Day <b>22</b> Year <b>70</b> Hour <b>3:01</b> P.M.	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Berryville</b>	
9. DATE OF BIRTH <b>Nov. 28, 1942</b>		10. AGE (in years last birthday) <b>28</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier</b>		15. MOTHER'S MAIDEN NAME <b>Hazel B. Downin</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 25 Apr 63</b>		17. SOCIAL SECURITY NO. <b>199-32-1544</b>	
18. INFORMANT <b>Mr. Curtis Cradler</b>		ADDRESS <b>42 W. Main, St. Waynesboro, Pa</b>	

19. CAUSE OF DEATH <b>Craniocerebral injuries</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
20A. DATE OF OPERATION <b>2</b>	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) <b>yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>12 20 70 10:30 a.m.</b>	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>HIGHWAY</b> 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Int. of Rt. 60 &amp; Ridenour Rd. approx. 6 miles N. of Hagerstown, Md.</b> 22F. HOW DID INJURY OCCUR? <b>Subject was driver in auto- auto collision.</b>

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12/23/70</b>

24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12-24-70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Harbaugh Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Smithsburg Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR ADDRESS <b>Davis Funeral Home Smithsburg, Md.</b>	

70 12848

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12647

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Judy Cradler				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 22 Year 70 Hour 2:02 p.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital				3. DATE PRONOUNCED DEAD Month 12 Day 22 Year 70 Hour 2:02 p.m.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Va. B. COUNTY Clark				6. SEX female 7. RACE White 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. DATE OF BIRTH June 29, 1945 10. AGE (In years last birthday) 25 11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Shirley T. Payne				14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse			
15. MOTHER'S MAIDEN NAME Phylis E. Robinson				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no			
17. SOCIAL SECURITY NO. 228-60-3671				18. INFORMANT ADDRESS Mr. Shirley T. Payne Hardy Road, Mt. Airy			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Craniocerebral Injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes				22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.			
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway				22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Int. of Rt. 60 & Kidenour Rd. approx. 6 miles N. of Hagerstown, Md.			
22D. TIME OF INJURY (APPROX.) 12 20 70 10:30 a.m.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22F. HOW DID INJURY OCCUR? Subject was a passenger in an auto accident.				23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/23/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12-24-70			
24C. NAME OF CEMETERY or CREMATORY Harbaugh Cemetery				24D. LOCATION (City, town, or county) (State) Smithsburg, Maryland			
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1970				25B. NAME OF REGISTRAR Robert E. Fisher, M.D.			
25C. FUNERAL DIRECTOR Davis Funeral Home				ADDRESS Smithsburg, Md.			

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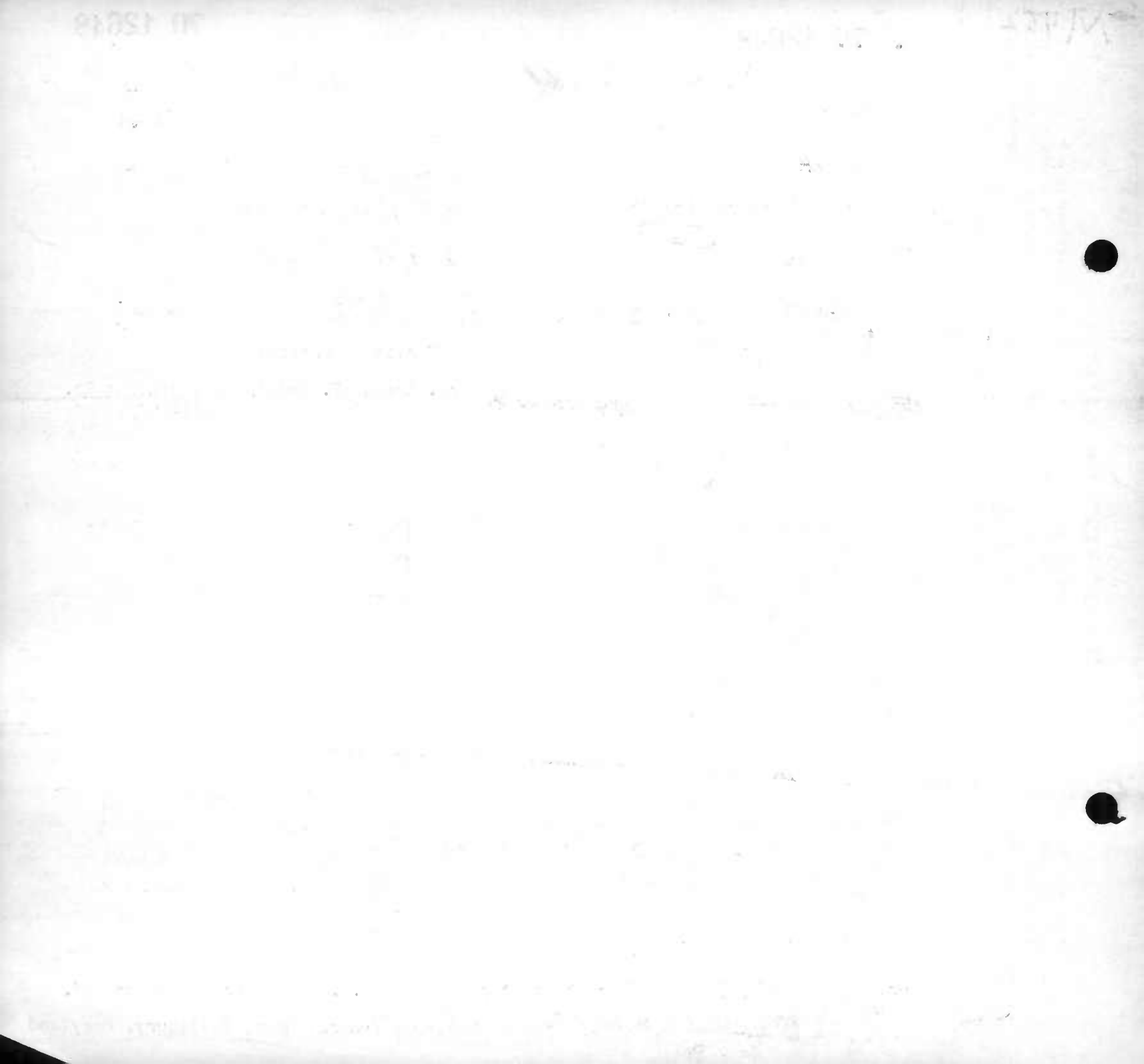
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

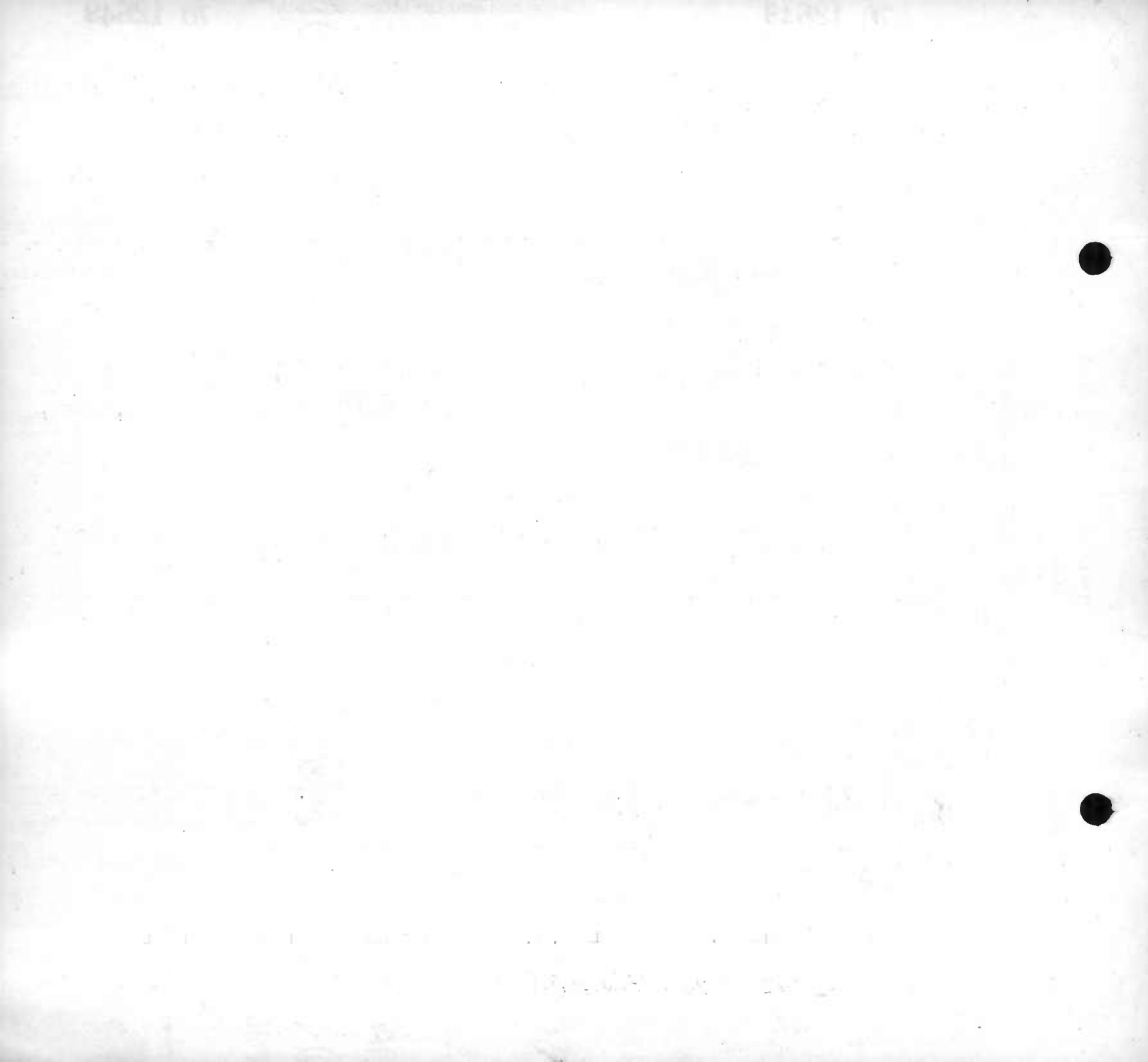
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 70 12648				
BIRTH NO. 70 12648					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) ALEXANDER (sander) MELNIK					2. DATE AND HOUR OF DEATH 12/23/70 6 30 P M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Maryland General Hospital					A. STATE MD. B. COUNTY Wicomico 7212				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) SALISBURY				
					D. STREET ADDRESS (If rural, give location) 917 VINCENT ST.				
5. SEX M		6. RACE W		7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 6/9/17		9. AGE (In years lost birthday) 53	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY Mfg. Company		11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Joseph Melnik					14. MOTHER'S MAIDEN NAME Terise Kossma				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II					16. SOCIAL SECURITY NO. 384-03-0538		17. INFORMANT Mrs. Louise E. Melnik, 917 Vincent St. Salisbury, Maryland		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					CAUSE OF DEATH (A) CARDIAC ARREST DUE TO (B) BRAIN TUMOR DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH 1/2 HR 6 WKS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 01/15/70			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BRAIN TUMOR			20A. AUTOPSY? (Yes or No) N/O		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 11/5 to 12/23 1970, that (1) (we) lost saw the deceased alive on 12/23 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Kristin Stueber MD					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 12/23/70	
23C. PHYSICIAN'S NAME (Type) KRISTIN STUEBER					23D. ADDRESS MD Gen Hosp				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/27/70		24C. NAME of CEMETERY or CREMATORY Shad Point Cemetery			24D. LOCATION (City, town, or county) (State) R.D., Salisbury, Wicomico, Md.		
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1970			25B. NAME OF REGISTRAR Robert E. Tabor, MD			25C. FUNERAL DIRECTOR ADDRESS Holloway Funeral Home, Salisbury, Maryland			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

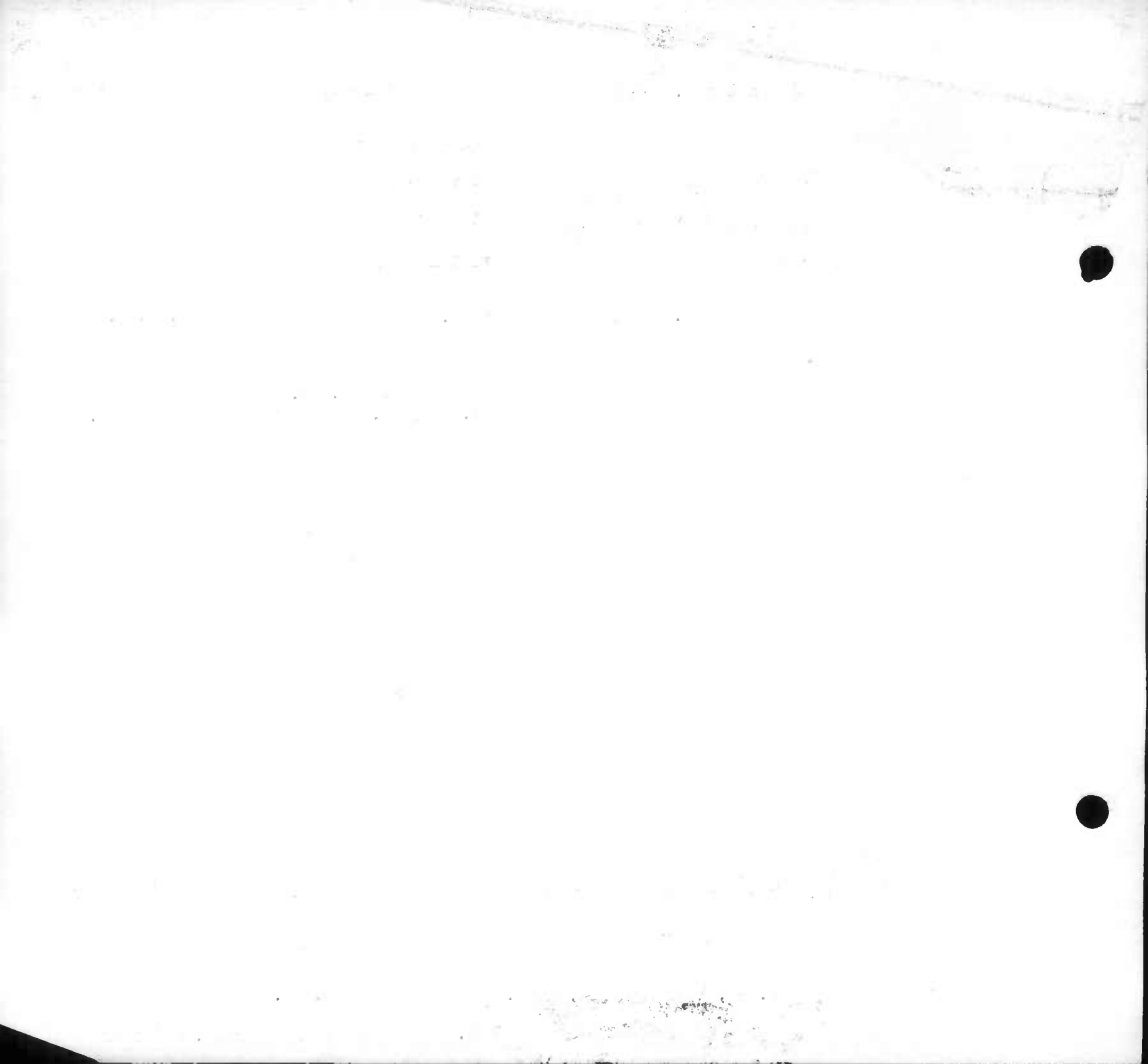
Baltimore City Health Department				X REG. NO.	
<div> <div>70 12649</div> <div>CERTIFICATE OF DEATH</div> <div>70 12649</div> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)			
		Hagerstown, Md. Knight, baby boy David Eugene Jr.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH			
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY WASHINGTON			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Hagerstown		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER					
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/2/70	9. AGE (In years last birthday) 0	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Davide Knight		14. MOTHER'S MAIDEN NAME Bonnie Sue Rhodes	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT DAVID E. KNIGHT	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory failure		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Diaphragmatic Hernia DUE TO, OR AS A CONSEQUENCE OF:		4 hrs.	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 12/22/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Diaphragmatic hernia		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 22, 1970 to December 25, 1970, that (I) (we) lost saw the deceased alive on December 25, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE David G. Ansel M.D.				23B. DATE SIGNED 12/25/70	
23C. PHYSICIAN'S NAME (Type) DAVID G. ANSEL M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/27/70		24C. NAME OF CEMETERY or CREMATORY Mt. View Cemetery	
24D. LOCATION SHARPSBURG, WASH., MARYLAND		24E. DATE REC'D BY HEALTH DEPT. DEC 30 1970		24F. NAME OF REGISTRAR Robert E. Taylor, M.D.	
24G. FUNERAL DIRECTOR ALBERT L. LEAF WILLIAMS		24H. ADDRESS SPORTS, MD.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

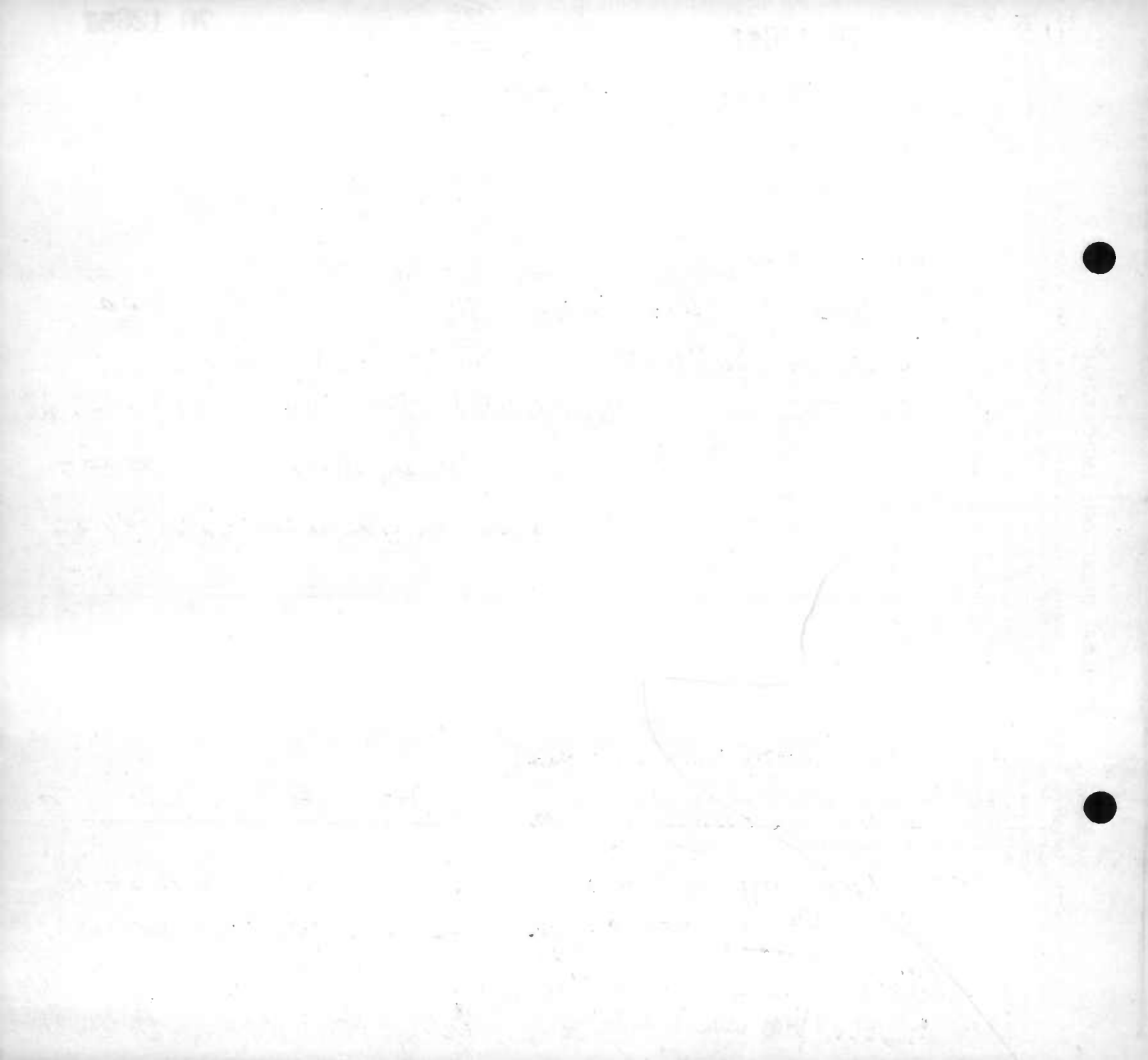
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12630</u>	
70 12650				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Jeannette A. Feuss		12-26-70 10:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  40 ST. AGNES HOSPITAL WILKENS & CATON AVENUES BALTIMORE, MARYLAND 21229			A. STATE Maryland 21229 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 410 Old Orchard Road		
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH J-31-01 ?	9. AGE (In years lost birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10B. KIND OF BUSINESS OR INDUSTRY Md. Doctor		11. BIRTHPLACE (State or foreign country) Balto.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Henry H. Feuss			
14. MOTHER'S MAIDEN NAME Alida Hooper		15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO.		17. INFORMANT Balto. Md. 21207 Mr. Zenus B. Hooper 3612 Forest Hill Rd.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  450X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  Pulmonary Embolism  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH approx hr.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L.N. D'Elia Jr.				23B. DATE SIGNED 12/26/70	
23C. PHYSICIAN'S NAME (Type) L.N. D'ELIA Jr.				23D. ADDRESS ST. AGNES HOSPITAL - Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 29, 1970		24C. NAME OF CEMETERY OR CREMATORY Greenmount Cem.	
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 30 1970			
25B. NAME OF REGISTRAR Robert E. Talbot		25C. FUNERAL DIRECTOR G. Truman Schwab 5151 Balto. National Pk			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 12651</b>	
BIRTH NO. <b>70 12651</b>				12651	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
<b>GRACE V SULLIVAN</b>			<b>12-25-70</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Mem Hosp</b>			A. STATE <b>Md</b> B. COUNTY <b>1348</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <b>3631 Ash Street</b>			9. AGE (In years last birthday) <b>78</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Drug Chain</b>		11. BIRTH PLACE (State or foreign country) <b>Md</b>	
13. FATHER'S NAME <b>Samuel A Sullivan</b>		14. MOTHER'S MAIDEN NAME <b>Ella A. Strickland</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, (If unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216094575</b>		17. INFORMANT <b>Mrs Irene Burgee</b> ADDRESS <b>3631 Ash St</b>	
18. <b>410.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary Thrombosis</b> (B) <b>Hypertensive Cardio-vascular disease</b> (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7-21 1961</b> to <b>12-25 1970</b> , that (I) (we) last saw the deceased alive on <b>12-12 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Reuben Hoffman, M.D.</b>				23B. DATE SIGNED <b>12-28-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>REUBEN HOFFMAN, M.D.</b>				23D. ADDRESS <b>846 W. 36th St., BALTIMORE, MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-29-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem</b>	
24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Brlto Co Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.A.</b>	
25C. FUNERAL DIRECTOR <b>Burgee Funeral Home Brlto Md</b>		25D. ADDRESS <b>Bu Normal Baltimore Co</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 12632</b>	
BIRTH NO. <b>70 12652</b>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Evan H. Ensor</b>			2. DATE AND HOUR OF DEATH <b>12/28/70 1:30 PM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Union Memorial Hosp</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balt.</b> C. CITY OR TOWN <b>Owings Mills</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>Box 187 Rt. #1 ; Park Heights Ave</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>06-23-93</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Evan H Ensor</b>			14. MOTHER'S MAIDEN NAME <b>Unknown Wilhelmina Fowble</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>220-30-0022</b>		
17. INFORMANT ADDRESS <b>Mrs. Grace A. Ensor Owings Mills</b>					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Loaking Aortic Aneurysm</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Renal Failure</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/27</b> 19 <b>70</b> to <b>12/28</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>12/28</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>D.D. Crothers MD</b>				23B. DATE SIGNED <b>12/28/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>D.D. Crothers MD</b>				23D. ADDRESS <b>Union Memorial Hosp</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/30/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Bosley Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Cockeysville, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Faber, R.D.</b>		25C. FUNERAL DIRECTOR <b>J. F. Blinn &amp; Sons</b>	
				ADDRESS <b>Reisterstown Md</b>	

1950



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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <b>70 12653</b>	
BIRTH NO. <b>70 12653</b>		2. DATE AND HOUR OF DEATH <b>12/28/70 12:15a.m.</b>	
1. NAME OF DECEASED (Type or Print) <b>Scannell, Miss Hannah</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore Co.</b> C. CITY OR TOWN <b>Catonsville</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Bon Secours Hospital</b>		E. STREET AND NUMBER <b>27 Wade Ave. 21228</b>	
5. SEX <b>F</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>02/16/95</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		9. AGE (in years last birthday) <b>75</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Scannell, John</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <b>Lucy, Margaret</b>	17. INFORMANT <b>Admission Sheet.</b>
16. SOCIAL SECURITY NO. <b>215-50-9425</b>		ADDRESS	
18. <b>1977-8-1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE <b>GI bleeding</b> DUE TO, OR AS A CONSEQUENCE OF: <b>2 days</b> (B) <b>Adenocarcinoma of Portal hepatic</b> DUE TO, OR AS A CONSEQUENCE OF: <b>known 1 month</b> (C) _____	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-27</b> 19 <b>70</b> to <b>12-27</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>12-27</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Janice Voraraksa</b>		23B. DATE SIGNED <b>12-27-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>JANICE VORARAKSA</b>		23D. ADDRESS <b>BSH</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-31-70</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Talley, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Edmund</b>		25D. ADDRESS <b>21228</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

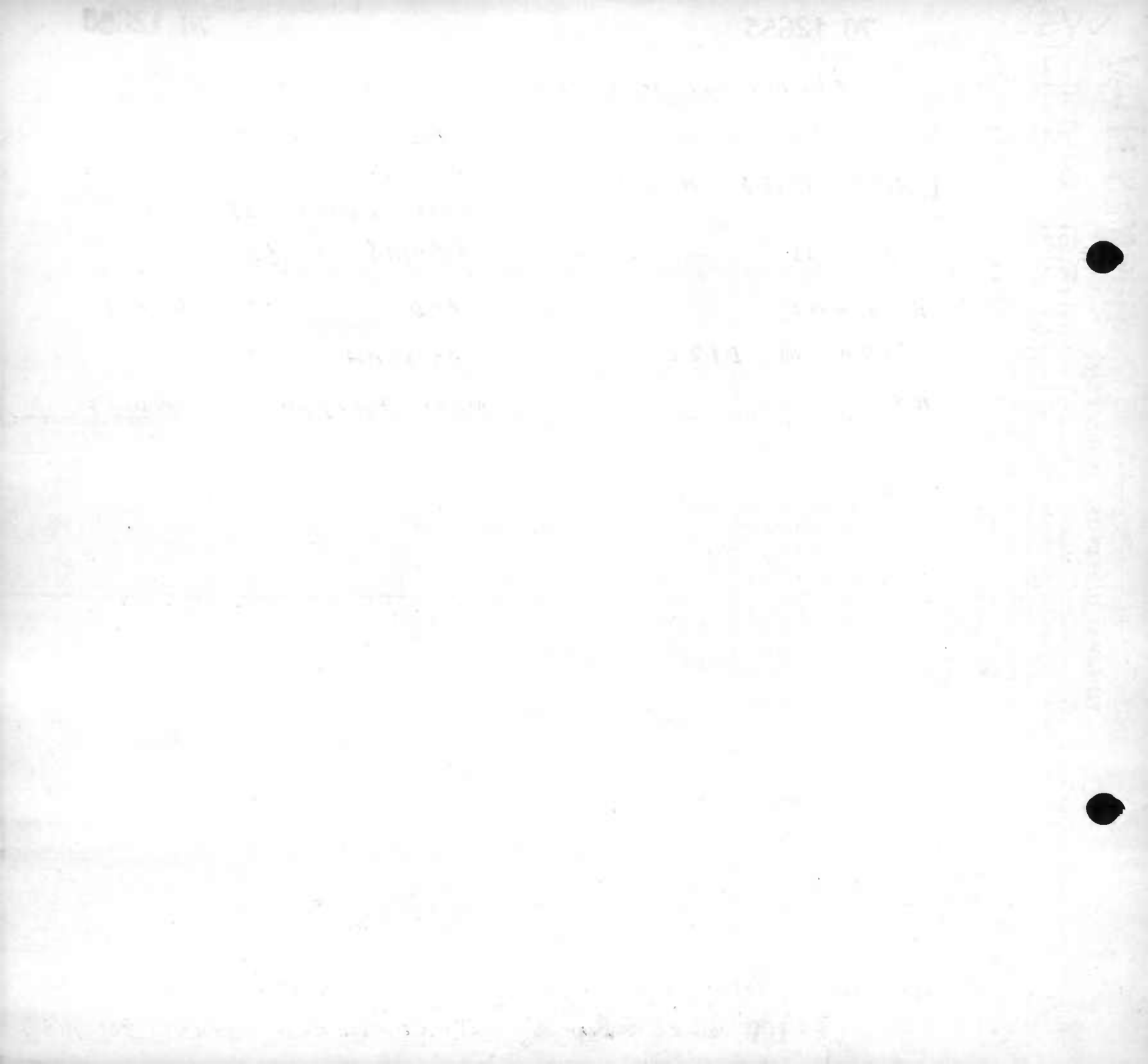
BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <b>70 12654</b>	
BIRTH NO. <b>70 12654</b>		1. NAME OF DECEASED (Type or Print) <b>EVERING, Mrs MARIE</b>	
2. DATE AND HOUR OF DEATH <b>12/28/70 12 40 P.M.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CHURCH HOME AND HOSPITAL</b>	
4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>BALTIMORE</b> B. COUNTY <b>5300</b>		5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME AND HOSPITAL</b>	
6. CITY OR TOWN <b>BALTIMORE</b>		7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. STREET AND NUMBER <b>7000, GOLDENRING ROAD</b>		9. SEX <b>F</b>	
10. RACE <b>W</b>		11. MARIED <input type="checkbox"/> NEVER MARIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
12. DATE OF BIRTH <b>5-12-92</b>		13. AGE (In years last birthday) <b>78</b>	
14. If Under 1 Yr. Months: <b>16</b> Days: <b>16</b> Hours: <b>16</b> Min. <b>16</b>		15. If Under 24 Hrs. Min. <b>16</b>	
16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME MAID</b>		17. KIND OF BUSINESS OR INDUSTRY <b>HOME MAID</b>	
18. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		19. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
20. FATHER'S NAME <b>JOHN GREEN</b>		21. MOTHER'S MAIDEN NAME <b>Caroline ? Olschinsky</b>	
22. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		23. SOCIAL SECURITY NO. <b>212-16-6229</b>	
24. INFORMANT <b>John W. Evering</b>		25. ADDRESS <b>1832 Hanford Rd.</b>	
26. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Recurrent cerebrovascular accident</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>chronic hypertension</b>		27. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12-10-70 to 12-28-70</b>	
28. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
29. DATE OF OPERATION <b>21</b>		30. CONDITION FOR WHICH OPERATION WAS PERFORMED	
31. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		32. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
33. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		34. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
35. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		36. HOW DID INJURY OCCUR?	
37. I certify that (I) (this hospital) attended the deceased from <b>Dec 12 1970</b> to <b>Dec 28 1970</b> that (I) (we) last saw the deceased alive on <b>Dec 28 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
38. SIGNATURE <b>W. Vincent Pappalardo</b>		39. DATE SIGNED <b>12/28/70</b>	
40. PHYSICIAN'S NAME (Type) <b>W. Vincent Pappalardo</b>		41. ADDRESS <b>100 N. Broadway St. (31)</b>	
42. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		43. DATE <b>12-31-70</b>	
44. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>		45. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	
46. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>		47. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
48. FUNERAL DIRECTOR <b>Philip E. Bach</b>		49. ADDRESS <b>1211 Chesaco Ave</b>	

Handwritten text at the bottom of the page, possibly a signature or date, which is mostly illegible due to fading. Some characters like '1911' and '10' are faintly visible.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 12655</b>	
70 12655		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>PLUMA V. WINSTEAD</b>		2. DATE AND HOUR OF DEATH <b>DEC. 25, 1970</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b>		M. <b>5300</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTO. CITY HOSP</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>EASTPOINT</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>5/14/88</b>		9. AGE (In years last birthday) <b>82</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>M.D.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN M. DIZE</b>		14. MOTHER'S MAIDEN NAME <b>ARINTHA P</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MARY KAZVAC</b> ADDRESS <b>ABOVE</b>	
18. <b>410.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arterioscler. heart dis. 20 years</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Immediate</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>20 years</b> (C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1950</b> to <b>8 Aug</b> <b>1970</b> , that (I) (we) last saw the deceased alive on <b>8 Aug</b> <b>1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>B. W. SOLLER</b>		23B. DATE SIGNED <b>12-28-70</b>		23C. PHYSICIAN'S NAME (Type) <b>B. W. SOLLER</b>	
23D. ADDRESS <b>2900 DUNRAVILL</b>		23E. FUNERAL DIRECTOR <b>J. G. CORNELLY</b> ADDRESS <b>300 MACE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24B. DATE <b>12/29/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>V.A. CEM.</b>	
24D. LOCATION (City, town, or county) <b>CRISFIELD MD</b>		24E. STATE (State) <b>MD</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Talley, MD.</b>		25C. FUNERAL DIRECTOR <b>J. G. CORNELLY</b> ADDRESS <b>300 MACE</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

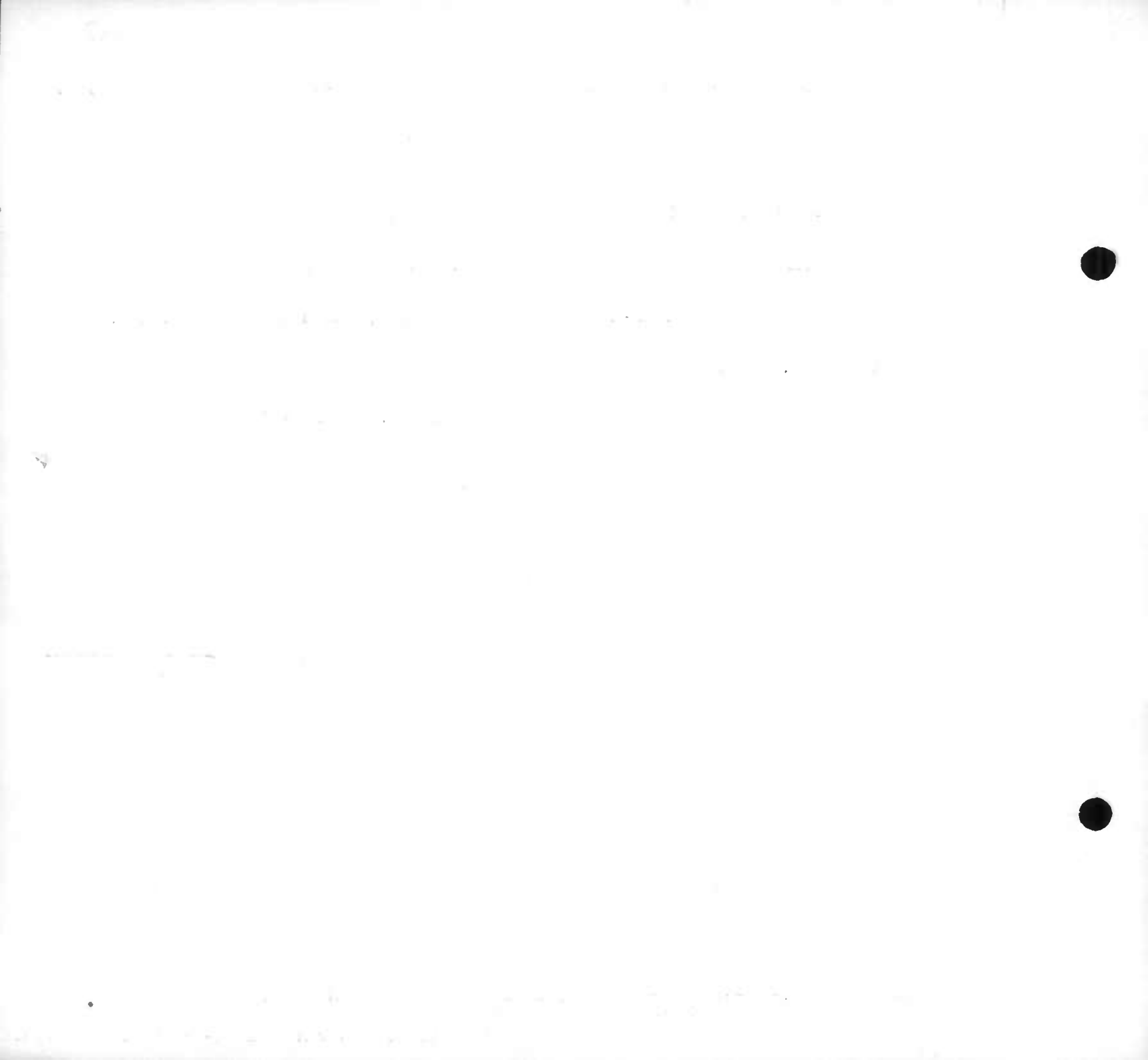
BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH											
BIRTH NO. <u>70 12656</u>				REG. NO. <u>70 431020</u>							
1. NAME OF DECEASED (Type or Print) <u>ESSEX, M.D.</u> <u>SUTPHIN, KENNETH</u>				2. DATE AND HOUR OF DEATH <u>8 AM</u> <u>12/25/70</u> M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 Sinai Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALT</u> C. CITY OR TOWN <u>ESSEX</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>728 CONROY RD</u>							
5. SEX <u>M</u>	6. RACE <u>Can</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/10/68</u>	9. AGE (in years lost birthday) <u>2</u>	If Under 1 Yr. Months Days			If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Essex M.D.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>DAVID SUTPHIN</u>				14. MOTHER'S MAIDEN NAME <u>Thelma PHILLIPS</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>PARENTS</u> ADDRESS <u>ABOVE</u>			
18. <u>2079 I</u> CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>peritonitis; bowel perforation</u>											
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>leukemia</u>											
(B) DUE TO, OR AS A CONSEQUENCE OF:											
(C) DUE TO, OR AS A CONSEQUENCE OF:											
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION <u>12/25/70</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>12/23</u> 19 <u>70</u> to <u>death</u> 19 <u>70</u> that (1) (we) last saw the deceased alive on <u>12/23</u> 19 <u>70</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Kenneth B. Roberts M.D.</u> DEGREE <u>MD</u> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>								23B. DATE SIGNED <u>12/25/70</u>			
23C. PHYSICIAN'S NAME (Type) <u>Sinai Hospital, Balt Md.</u>								23D. ADDRESS			
24A. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>12/29/70</u>				24C. NAME OF CEMETERY OR CREMATORY <u>HOLLY HILLS</u>			
24D. LOCATION (City, town, or county) <u>BALTO.</u>				(State) <u>MD.</u>							
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>				25C. FUNERAL DIRECTOR <u>J. W. CONNELLY SONS</u> ADDRESS <u>300 MACE</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 12657				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 12657	
1. NAME OF DECEASED (Type or Print) <b>Charles Thomas Newton</b>				2. DATE AND HOUR OF DEATH <b>12-27-70</b>		2:55 p.m. <span style="float: right;">M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>90 Pleasant Manor Nursing Home</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1510</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>4116 Boarman Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 14, 1893</b>		9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>P.R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>Arlington, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William T. Newton</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Charles T. Newton-2645 Maryland Avenue</b>			
18. <b>412.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>CVA.</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Hypertensive CV. Disease.</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Arteriosclerosis</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>July 7, 1963</b> to <b>Dec 27, 1970</b> that (I) (we) lost saw the deceased alive on <b>Dec 27, 1970</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Nathan E. Needle MD</b>				23B. DATE SIGNED <b>12/28/70</b>		23C. PHYSICIAN'S NAME (Type) <b>NATHAN E. NEEDLE</b>	
23D. ADDRESS <b>6506 Park Hgts Br Jacob Ave 21215</b>		24. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					
24B. DATE <b>12-30-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 30 1970</b>		25B. NAME OF REGISTRAR <b>John E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Armacost Funeral Chapel-4600 Liberty Hgts</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

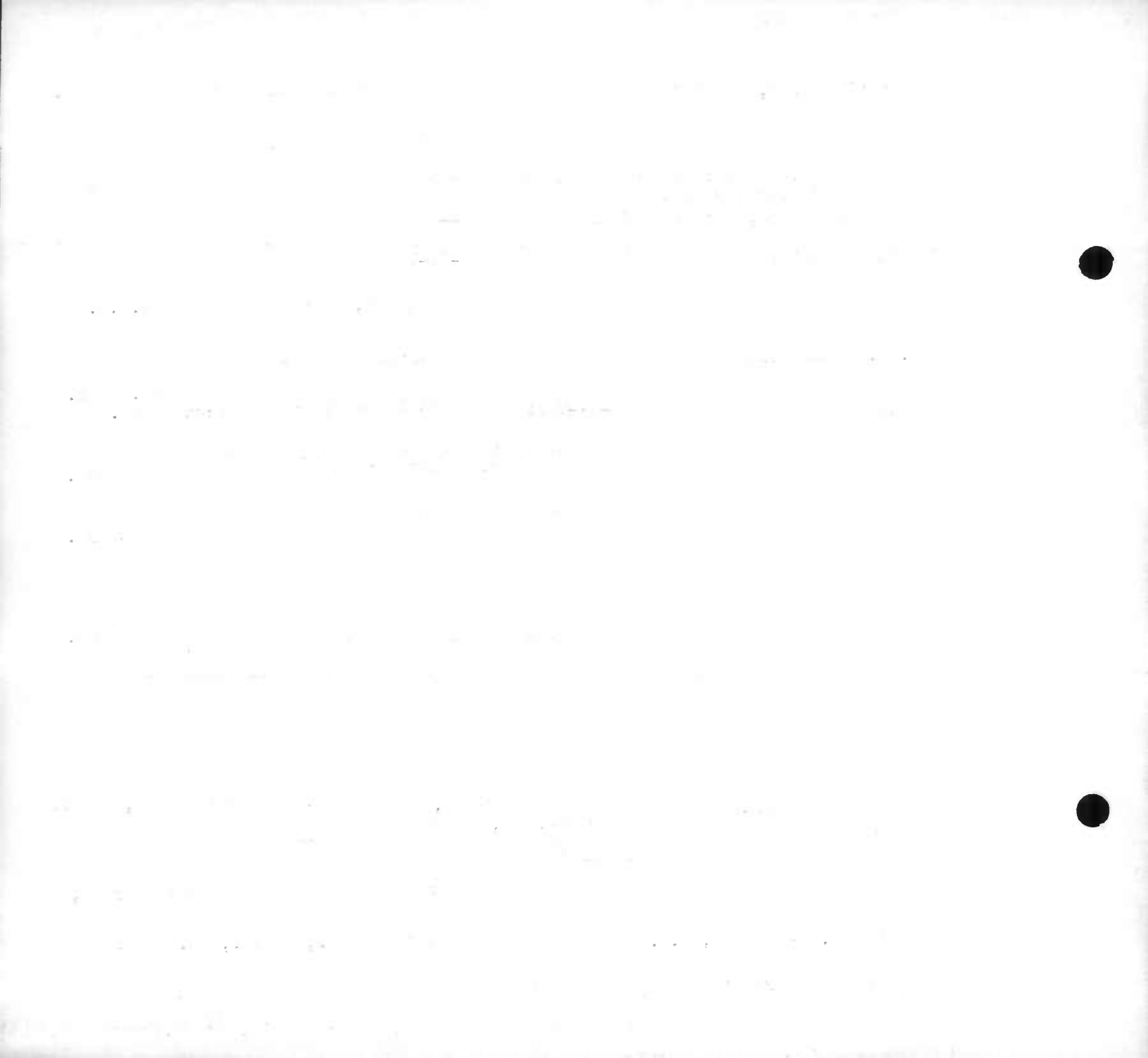
W 635-1

70 12658

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 12658

BIRTH NO. 70 12658		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 12658	
1. NAME OF DECEASED (Type or Print) <b>WORTHINGTON, Eleanor</b>			2. DATE AND HOUR OF DEATH <b>December 26, 1970 2:40 P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>19 The Seton Psychiatric Institute 6400 Wabash Avenue Baltimore, Maryland 21215</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Montgomery County 6500</b> C. CITY OR TOWN <b>Garret Park</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>--</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-13-79</b>	9. AGE (In years lost birthday) <b>91</b>	If Under 1 Yr. Months: Days: Hours: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (State or foreign country) <b>Chillicathe, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>R. T. Worthington</b>			14. MOTHER'S MAIDEN NAME <b>Mary Arobella Piatt</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Doubtful</b>		16. SOCIAL SECURITY NO. <b>220-54-6975</b>	17. INFORMANT ADDRESS <b>The Seton Psy. Inst. Hospital Records - 6400 Wabash Ave.</b>		
18. <b>433.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral vascular thrombosis, with recurrent stroke syndrome</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral and general arteriosclerosis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Schizophrenia, Chronic undifferentiated type.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b> <b>15 yrs.</b> <b>70 yrs.</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 6, 19 14</b> to <b>December 26, 19 70</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>December 26, 19 70</b> and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Walter O. Jahrreiss M.D.</b>			23B. DATE SIGNED <b>December 26, 1970</b>		Attending Phys. <input type="checkbox"/> for Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>Walter O. Jahrreiss, M.D.</b>			23D. ADDRESS <b>6400 Wabash Ave., Balto., Md. 21215</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>12/30/70</b>	24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore City, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>STEWART &amp; MOWEN CO. 108 W. North Av. City</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

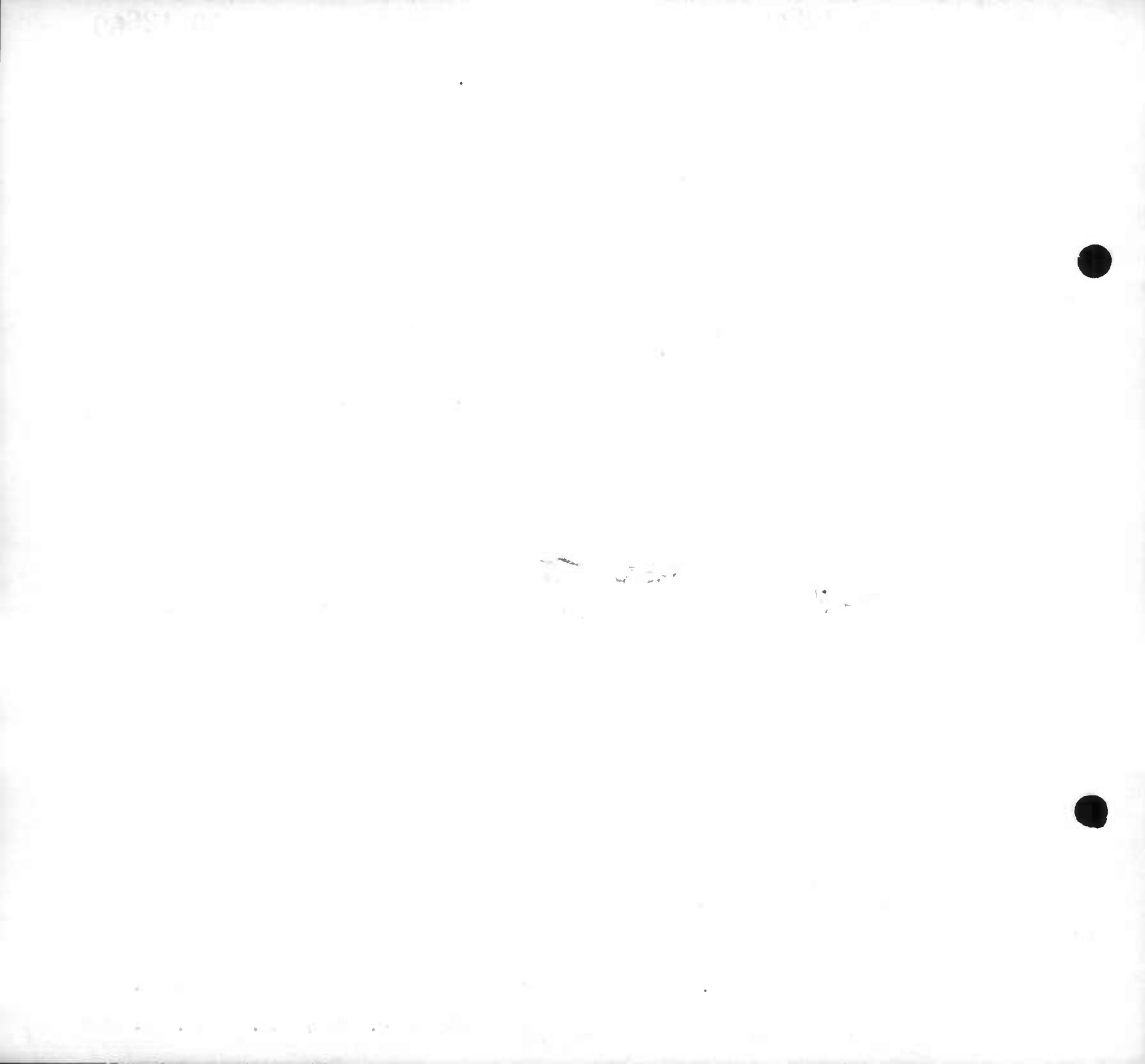
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>70 12659</b>	
70 12659		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>NELSON D MIDDLETON</b>		12/24/70 6:30 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital</b>		A. STATE <b>Maryland</b> B. COUNTY <b>5300</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <b>7953 Bank St.</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-10-10</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>chipper</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <b>60</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>David Middleton</b>		14. MOTHER'S MAIDEN NAME <b>Mary Vaneant</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-10-1245</b>	
17. INFORMANT <b>Wife Mrs. Nelson Middleton</b>		ADDRESS <b>above</b>	
18. <b>157.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Carcinoma of the head of pancreas</b>	
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>metastasis in the mediastinum</b>	
		DUE TO, OR AS A CONSEQUENCE OF:	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>3/19/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>for adenoma</b>	
20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12/19/70</b> 19 to <b>12/24</b> 1970 that (I) (we) last saw the deceased alive on <b>12/24/70</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Pratima Bose MD</b>		23B. DATE SIGNED <b>12/24/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>PRATIMA BOSE MD</b>		23D. ADDRESS <b>Mercy Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Dec. 28</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Chesterfield</b>		24D. LOCATION (City, town, or county) (State) <b>centreville, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>	
25C. FUNERAL DIRECTOR <b>Thane F. H. Church Hill, Md.</b>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12660		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12660	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>RUPPRECHT, GEORGE Wm.</u>		2. DATE AND HOUR OF DEATH <u>12/26/70 1 7 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>BALTO</u> B. COUNTY <u>MD</u>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>MERBY Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>1841 N. MILTON AVE</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/17/03</u>	9. AGE (in years last birthday) <u>67</u>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECURITIES COURIER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>BANK</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William J. Rupprecht</u>		14. MOTHER'S MAIDEN NAME <u>KATHYRN FORD</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>21503-5805</u>		17. INFORMANT <u>Mrs. Mildred M. Rupprecht</u>	
18. <u>4109 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>MASSIVE UPPER GASTROINTESTINAL BLEEDING &amp; PANCREATITIS.</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARDIAC ARREST</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u>	
(B) MYOCARDIAL ISCHEMIA & INFARCTION DUE TO, OR AS A CONSEQUENCE OF: <u>48 HRS</u>		(C) ASQVD			
19A. DATE OF OPERATION <u>12/24/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>SUSPECTED GASTROINTESTINAL BLEEDING &amp; DUODENAL ULCER</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>(Month) (Day) (Year) (Hour)</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>12/24</u> 19 <u>70</u> to <u>12/26</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>12/26</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>S. J. Demareo III</u>		23B. DATE SIGNED <u>12/26/70</u>		23C. PHYSICIAN'S NAME (Type) <u>S. J. DEMAREO III MD</u>	
23D. ADDRESS <u>222 ST. PAUL PL. BALTO MD</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/30/70</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		24D. LOCATION <u>Baltimore, Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1970</u>	
24F. NAME OF REGISTRAR <u>Robert E. J. J. J.</u>		24G. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		24H. ADDRESS <u>21214</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M 300 1

70 12661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

70 12661

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

MATTIO, DOMINIC MICHAEL

2. DATE AND HOUR OF DEATH

December 27, 1970 12:40 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Veterans Administration Hospital  
3900 Loch Raven Boulevard  
Baltimore, Maryland 21218

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE B. COUNTY  
Maryland Baltimore

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

5438 Hilltop Ave.

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

5-26-16

9. AGE (in years)

54

10. Under 1 Yr.

Months

Days

Hours

Min.

11. Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Taxicab Driver

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Daniel Mattio

14. MOTHER'S MAIDEN NAME

Rosalee Page

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

Yes

4-6-42 to 9-1-45

16. SOCIAL SECURITY NO.

216-07-1353

17. INFORMANT Records V. A. Hospital ADDRESS

3900 Loch Raven Blvd., Baltimore, Md. 21218

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE Carcinoma of Lung, Left  
DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

5 Months

(B) Bronchopneumonia  
DUE TO, OR AS A CONSEQUENCE OF:

25 Days

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Congestion and Edema of lungs, marked

25 Days.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that II (this hospital) attended the deceased from December 3, 19 70 to December 27, 19 70 that II (we) last saw the deceased alive on December 27, 19 70 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. II (We) (did) (did not) view the body after death.

23A. SIGNATURE

Jamie F. Casellas

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

12-27-70

23C. PHYSICIAN'S NAME (Type)

Jamie F. Casellas, MD

23D. ADDRESS

V. A. Hospital

3900 Loch Raven Blvd., Baltimore, Md. 21218

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/31/70.

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 30 1970

25B. NAME OF REGISTRAR

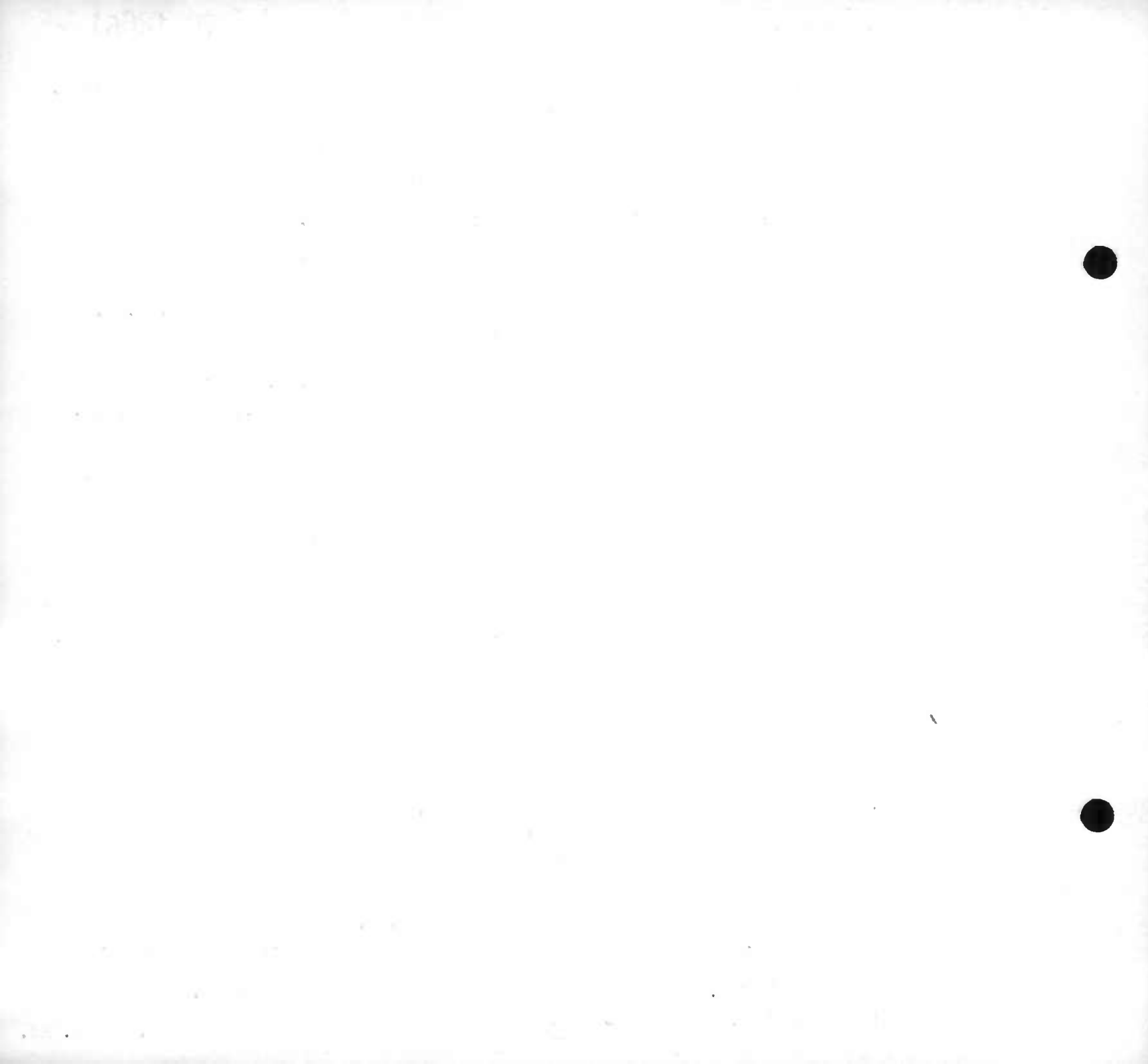
Robert E. Fisher, M.D.

25C. NAME OF FUNERAL DIRECTOR

Thomas J. Ruck

ADDRESS

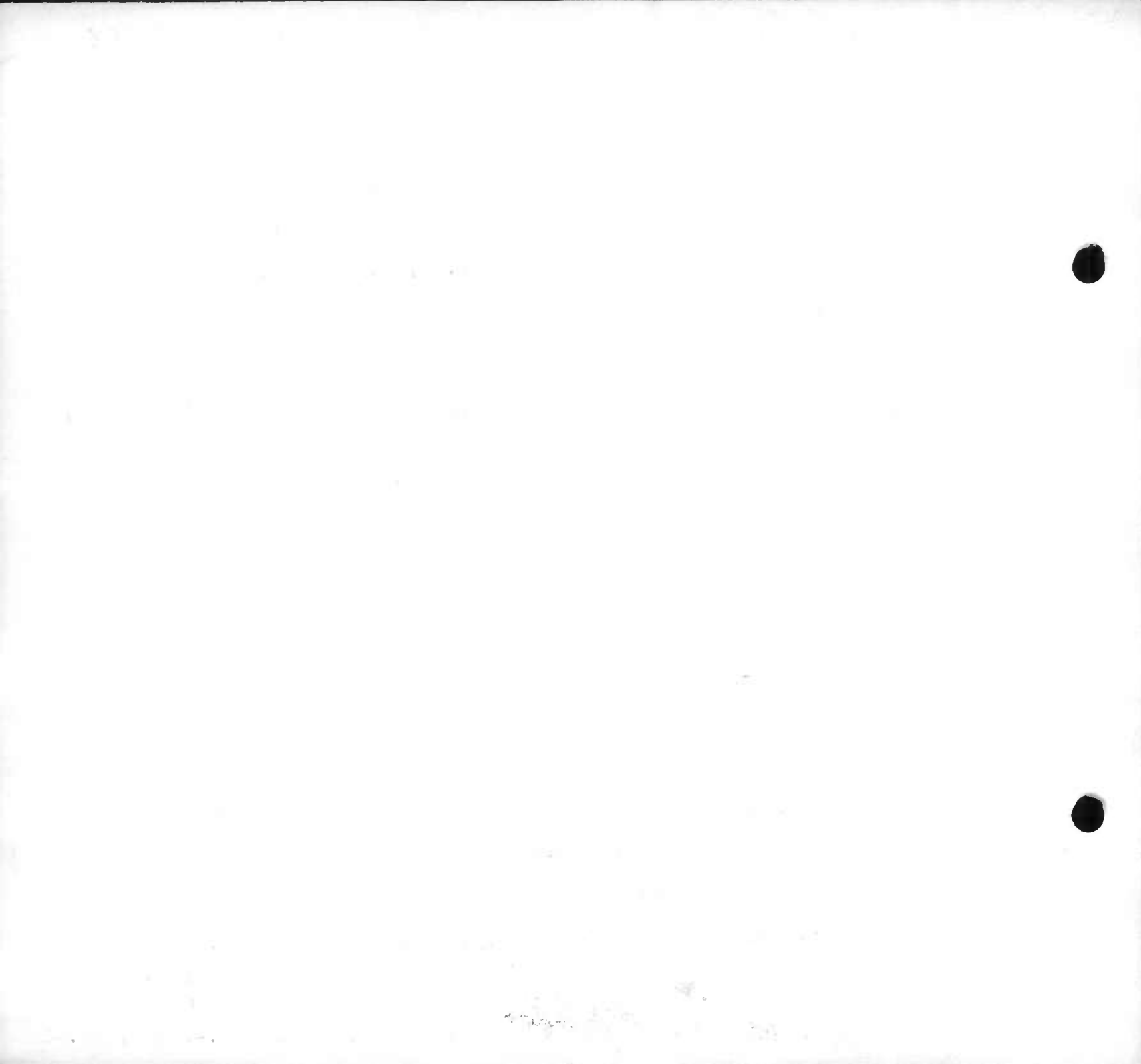
Inc. Balto. Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

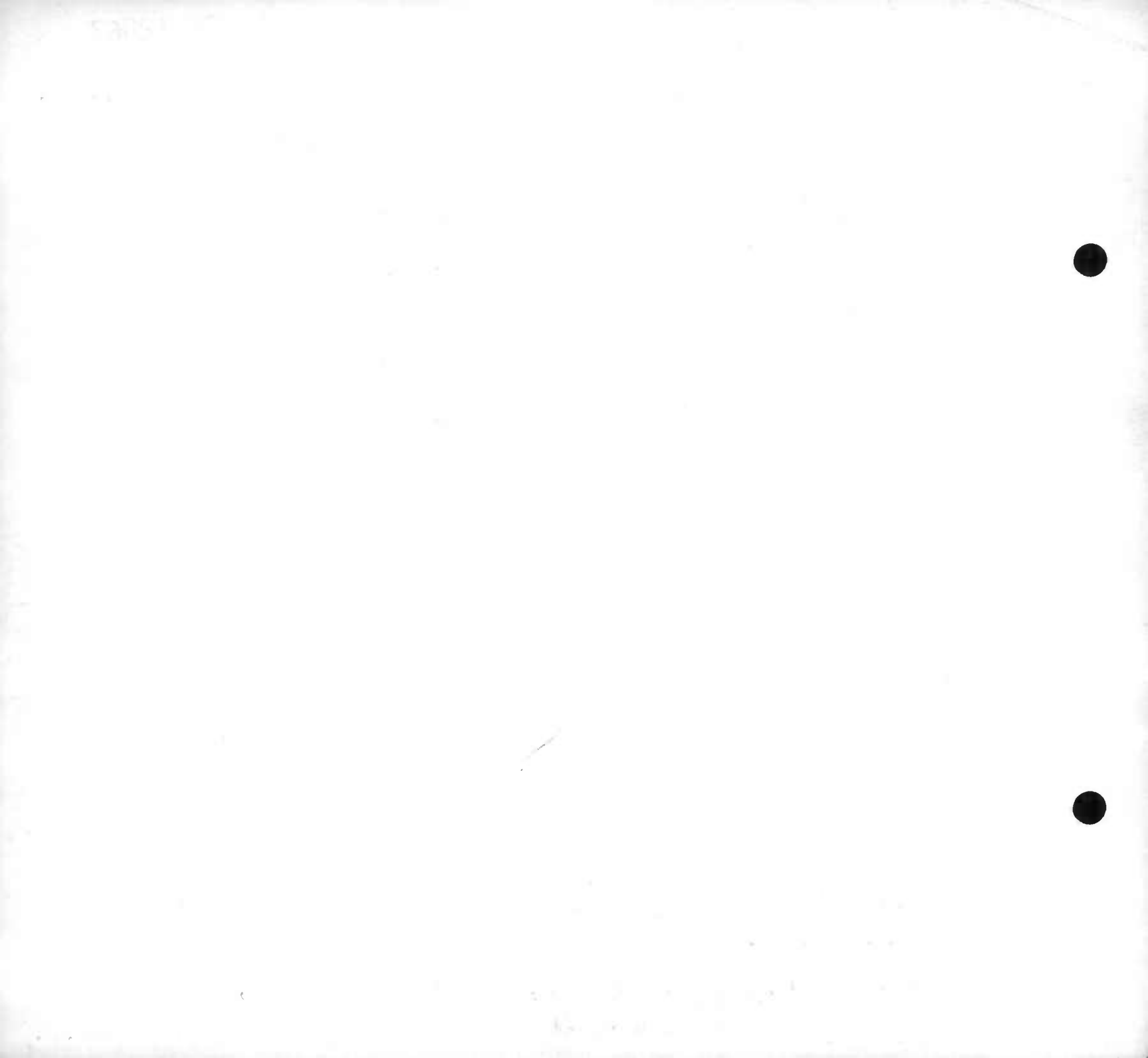
70 12662		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 12662	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		DORIS DiPAOLA		Dec. 25, 1970 12 <sup>20</sup> A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
1912 Swansea Road--14			Maryland		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			1912 Swansea Road		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)
female	caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Oct. 28, 1915	55
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife				Kentucky	USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
James Whitt			Arley Adkins		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				Mr. Joseph DiPaola, 1912 Swansea Rd, 14	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
162.1 I			cardiac arrest & metastasis		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Jan - 1968 to 12/25 - 1970 that (I) (we) last saw the deceased alive on 12/20 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (didn't) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Joseph R. Liberto, M.D.				12/25/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Joseph R. Liberto				3508 Bank St, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12/30/70		Parkwood Cemetery	
				Blair-Hitch Farm Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 30 1970		Robert E. Faber, M.D.		Leonard J. Ruck, Inc.-Balto, Md.-14	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

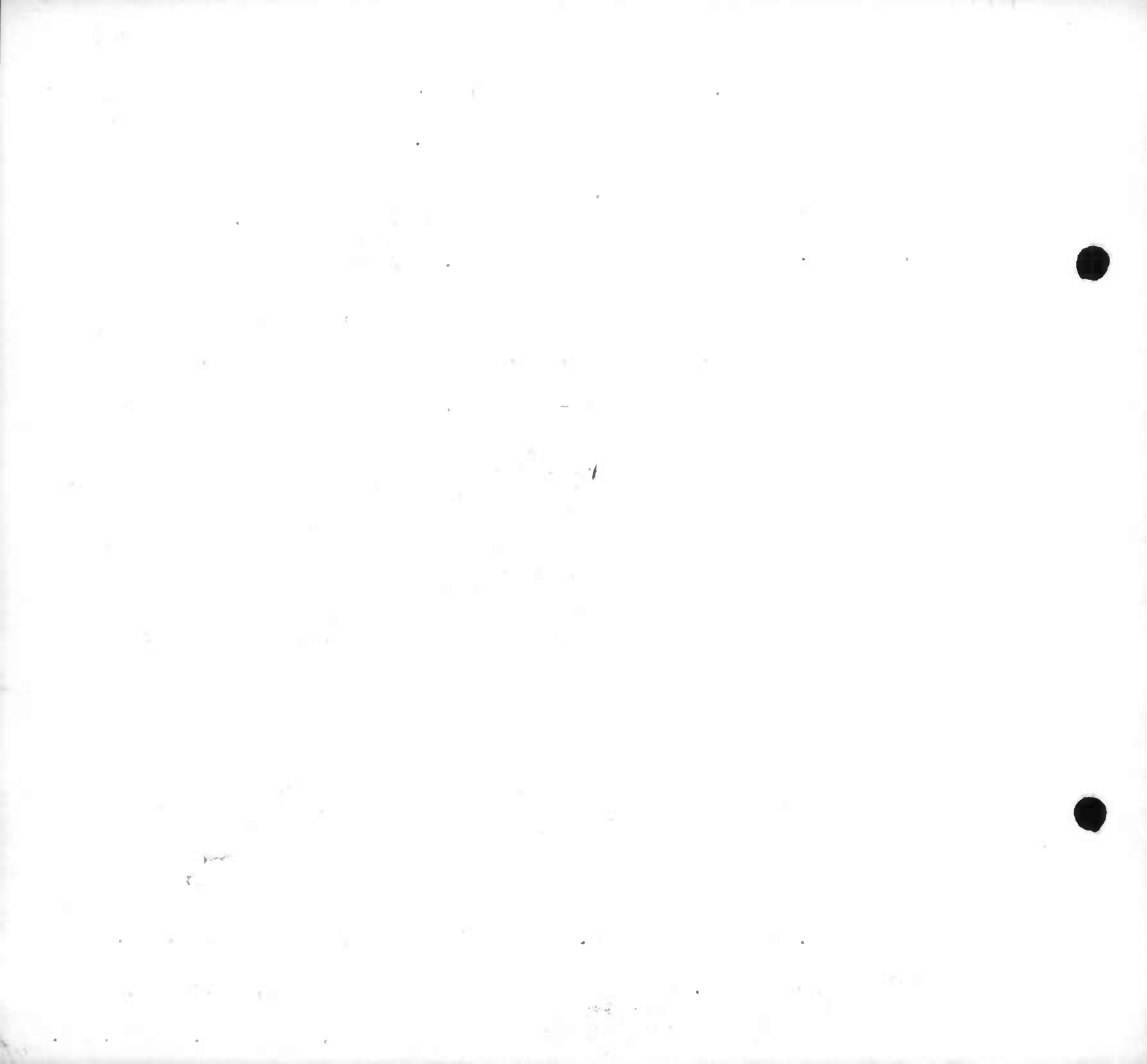
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>70 12663</b>	
BIRTH NO. <b>70 12663</b>					
1. NAME OF DECEASED (Type or Print) <b>DRISCOLL PATRICK JOSEPH</b>			2. DATE AND HOUR OF DEATH <b>12 25 70</b> <b>8:10 A. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BLVD BALTIMORE, MD</b>			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>TOWSON, MARYLAND</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>8122 LOCH RAVEN BLVD</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8 7 07</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>DENNIS DRISCOLL</b>		
14. MOTHER'S MAIDEN NAME <b>DELIA ROLLAND</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW2 5 7 42/ 4 4 43</b>		
16. SOCIAL SECURITY NO. <b>216 03 37 26</b>		17. INFORMANT ADDRESS <b>CLINICAL RECORDS VAH BALTIMORE, MD.</b>			
18. <b>4361 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>NONE</b> 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO</b> 20A. AUTOPSY? (Yes or No) <b>NO</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (X) (this hospital) attended the deceased from <b>10/29/70</b> to <b>12 25</b> 19 <b>70</b> that (I) (We) last saw the deceased alive on <b>12 25</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <b>R.A. CASH</b> 23B. DATE SIGNED <b>12 26 70</b> 23C. PHYSICIAN'S NAME (Type) <b>R.A. CASH, M.D.</b> 23D. ADDRESS <b>VA HOSPITAL BALTIMORE, MARYLAND</b> 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b> 24B. DATE <b>12/29/70</b> 24C. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cemetery</b> 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b> 25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b> 25B. NAME OF REGISTRAR <b>Robert E. Talley</b> 25C. FUNERAL DIRECTOR <b>RUCK FUNERAL HOME</b> ADDRESS <b>5303 Harford Rd Balto. Md.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12664		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12664	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) George R. Donaldson, Jr.		2. DATE AND HOUR OF DEATH 12/25/70 18:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		5. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 00 5701 Birchwood Ave.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 5701 Birchwood Ave.	
6. SEX M.	7. RACE W.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 1911 Dec. 27, 1911	10. AGE (In years last birthday) 58	11. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Laurel, Delaware	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George R. Donaldson, Sr.		14. MOTHER'S MAIDEN NAME Mary E. Carter	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W 2		16. SOCIAL SECURITY NO. 213-10-7432		17. INFORMANT Mrs. Mary Mosley	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Due to, or as a consequence of: <i>Pericardial Coronary Infarction</i> (B) <i>Chronic myocarditis</i> Due to, or as a consequence of: (C) <i>Arteriosclerotic C-V disease</i> <i>Chronic obstructive pulmonary disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> <i>15 yrs</i>	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Sept 20, 1970</i> to <i>Dec 25, 1970</i> and that (I) (we) last saw the deceased alive on <i>Dec 24, 1970</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>H. V. Harbold M.D.</i>				23B. DATE SIGNED <i>Dec. 26, 1970</i>	
23C. PHYSICIAN'S NAME (Type) Harold V. Harbold MD.		23D. ADDRESS 4706 Harford Road Balto. MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/29/70		24C. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery	
24D. LOCATION (City, town, or county) (State) Laurel, Delaware.		25A. DATE REC'D BY HEALTH DEPT. DEC 30 1970			
25B. NAME OF REGISTRAR <i>Robert E. Faber, M.D.</i>		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.			



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70 12665

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12665

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mamie Foot		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 25 70 11:00 a.m.	
6. SEX female		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE colored		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH April 20 1895		10. AGE (in years lost birthday) 45	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 217-22-5549	
18. INFORMANT Rosie Richardson		ADDRESS 1015 Mulberry St	
19. CAUSE OF DEATH I 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: [Signature] M.D. EXAMINER'S NAME (Type): Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner DATE SIGNED: 12/26/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-30-70	
24C. NAME OF CEMETERY or CREMATORY Mt Carmel Cmt		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1970		25B. NAME OF REGISTRAR Robert E. Jaber, M.D.	
25C. FUNERAL DIRECTOR Ed Wilson		ADDRESS 1000 Grandway Ave	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 12666		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12666	
1. NAME OF DECEASED (Type or Print) ANNIE B. CLARK		2. DATE AND HOUR OF DEATH 12/28/70 11 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Lutheran Hospital of MD		4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE Maryland B. COUNTY 21216			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital of MD		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3340 Piedmont Ave.			
5. SEX F	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/5/91	9. AGE (in years last birthday) 79 yrs
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S.C.	
13. FATHER'S NAME Judge B. Wilson		14. MOTHER'S MAIDEN NAME Alice Reeder			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 212-12-2550		17. INFORMANT Judge B. Clark	
18. 431.014-250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cerebro Vascular Accident		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Haemorrhage?			
		(B) DUE TO, OR AS A CONSEQUENCE OF: HYPERTENSION			
		(C) ASPIRATION PNEUMONIA DIABETES MELLITUS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? NO INJURY	
22. I certify that (I) (this hospital) attended the deceased from 12/5/1970 to 12/28/1970 that (I) (we) last saw the deceased alive on 12/28/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE K George Thomas MD				23B. DATE SIGNED 12/28/70	
23C. PHYSICIAN'S NAME (Type) K GEORGE THOMAS MD				23D. ADDRESS Lutheran Hospital of MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-31-70		24C. NAME OF CEMETERY or CREMATORY Carmel	
24D. LOCATION (City, town, or county) (State) Carmel Md		25A. DATE REC'D BY HEALTH DEPT. DEC 30 1970			
25B. NAME OF REGISTRAR Robert E. Talley		25C. FUNERAL DIRECTOR Eliot D. Nelson			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12667		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12667	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JOHANNIE DOUGLAS</b>		2. DATE AND HOUR OF DEATH <b>12-26-70</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1604</b>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <b>2045 Harlem Ave.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>C</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		8. DATE OF BIRTH <b>11-5-1906</b> 9. AGE (In years last birthday) <b>64</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>JOHN DOUGLAS</b>	
14. MOTHER'S MAIDEN NAME <b>BELLE BLUE</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>262-16-2283</b>	
17. INFORMANT <b>Dennis Blue</b>		ADDRESS <b>Same</b>		18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Braden's Carcinoma of the esophagus</b> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>by Generalized Metastases</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-9-1970</b> to <b>12-18-1970</b> , that (I) (we) lost sight of the deceased alive on <b>12-18-1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jose M. Yosunico</b>		23B. DATE SIGNED <b>12/26/70</b>		23C. PHYSICIAN'S NAME (Type) <b>JOSE M. YOSUNICO</b>	
23D. ADDRESS <b>608 Washington Blvd., Laurel, Md.</b>		23E. DEGREE <b>DEGREE</b>		23F. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-30-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MT. AUBURN CEM.</b>	
24D. LOCATION <b>Baltimore</b>		24E. STATE <b>Md.</b>		24F. CITY OR TOWN <b>Baltimore</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>ELroy D. W. Lson</b>	
25D. ADDRESS <b>1000 Brantley Ave.</b>		25E. CITY OR TOWN <b>Baltimore</b>		25F. STATE <b>Md.</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A5201

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12668	
BIRTH NO. 70 12668					
1. NAME OF DECEASED (Type or Print) <u>ALONZO AMES</u>			2. DATE AND HOUR OF DEATH <u>12/22/70</u> <u>11:45 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital</u>			A. STATE <u>Maryland</u> B. COUNTY <u>1604</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>700 N. PAYSON STREET</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-00</u>	9. AGE (In years last birthday) <u>70</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>George Ames</u>		
14. MOTHER'S MAIDEN NAME <u>Foulta Bailey</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>212-09-1402</u>			17. INFORMANT <u>CHART</u>		
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ATHEROSCLEROTIC HEART DISEASE</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>12/22/1970</u> to <u>12/22/1970</u> that (I) (we) lost saw the deceased alive on <u>12/22/1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>			23B. DATE SIGNED <u>12/22/70</u>		
23C. PHYSICIAN'S NAME (Type) <u>S. BASU</u>			23D. ADDRESS <u>Lutheran Hospital of Maryland</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-29-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Chilmark Cent.</u>	
24D. LOCATION (City, town, or county) <u>Md</u>		24E. STATE <u>Md</u>		24F. COUNTY <u>Calvert</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor R.D.</u>		25C. FUNERAL DIRECTOR <u>Condon 100 Broadway St</u>	



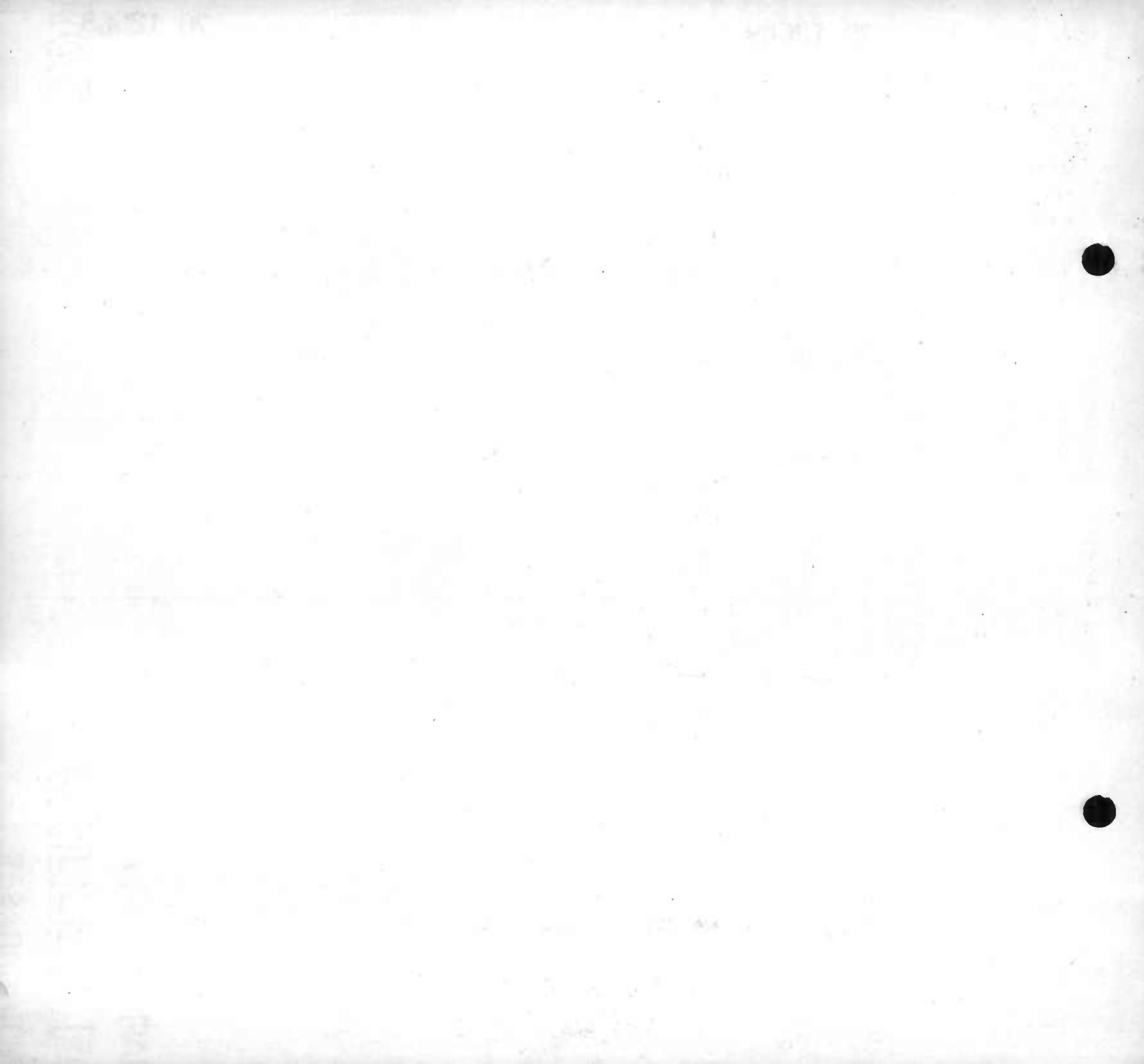
**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

REG. NO. **70 12669**

BIRTH NO. <b>70 12669</b>		2. DATE AND HOUR OF DEATH <b>12-25-70 2:05 P.M.</b>	
1. NAME OF DECEASED (Type or Print) <b>MARY WHITE</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 JOHNS HOPKINS HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>1536 N. WOLFE ST 21213</b>	
5. SEX <b>F</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-8-91</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>79</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ALEXANDER BAZZLE</b>		14. MOTHER'S MAIDEN NAME <b>IDA WATERS</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-30-5072</b>	17. INFORMANT <b>Shelma Martin</b>
18. <b>320.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>PNEUMOCOCCAL MENINGITIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>ACUTE BACTERIAL ENDOCARDITIS, PNEUMONIA</b>			
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>YES</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/18</b> 19 <b>70</b> to <b>12/25</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>12/25</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Benjamin L Portnoy MD</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <b>12/25/70</b>
23C. PHYSICIAN'S NAME (Type) <b>BENJAMIN L. PORTNOY</b>		23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Buried</b>	24B. DATE <b>12-20</b>	24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Natl Cemetery</b>	24D. LOCATION (City, town, or County) (State) <b>Baltimore</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>	25B. NAME OF REGISTRAR <b>Robert E. Farley</b>	25C. FUNERAL DIRECTOR <b>Edwison Brown</b>	ADDRESS <b>Edwison Brown</b>



70 12670

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12670

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDWARD W. GIBSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) DD 3436 Auchentoroly Terrace		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 25 1970 3:40 a M.	
6. SEX male		7. RACE negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 10. AGE (In years lost birth day) 52		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) BALTO. MARYLAND		E. STREET AND NUMBER 3436 Auchentoroly Terrace	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WILLIAM GIBSON	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME MARY AUSTIN	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give wgt or dates of service) YES		17. SOCIAL SECURITY NO. 212-18-7200	
18. INFORMANT ARTELIA GIBSON S/A		ADDRESS	
19. 412.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) NO			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. DATE SIGNED 12-25-70			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR		ADDRESS	

NO 15850

NO 15850

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple horizontal lines for text entry, including fields for patient information, medical history, and cause of death.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>70 12671</b>	
1. NAME OF DECEASED (Type or Print) <b>HARRY S. BAILEY</b>		2. DATE AND HOUR OF DEATH <b>12-23-70</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1513</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 St. Ann's Hosp. of Balt.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>4203 Pineville Rd.</b>			
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-17-1891</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES BAILEY</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN HARDY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HARRY J. BAILEY</b>	
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Coronal Vascular Disease 10 years</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 13</b> 19 <b>70</b> to <b>Dec 23</b> 19 <b>70</b> and that (I) (we) last saw the deceased alive on <b>Dec 13</b> 19 <b>70</b> and that (I) (my) (us) (we) (not) applan death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Simon H. Carter, Jr.</b>		23B. DATE SIGNED <b>24 Dec 70</b>		23C. PHYSICIAN'S NAME (Type) <b>Simon H. Carter, Jr., M. D.</b>	
23D. ADDRESS <b>4215 Park Heights Avenue #15</b>		23E. PHYSICIAN'S NAME (Type) <b>Simon H. Carter, Jr., M. D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12-23-70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balt. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR <b>Robert E. Taylor</b>		25D. ADDRESS <b>214 E. W. Wilson</b>	

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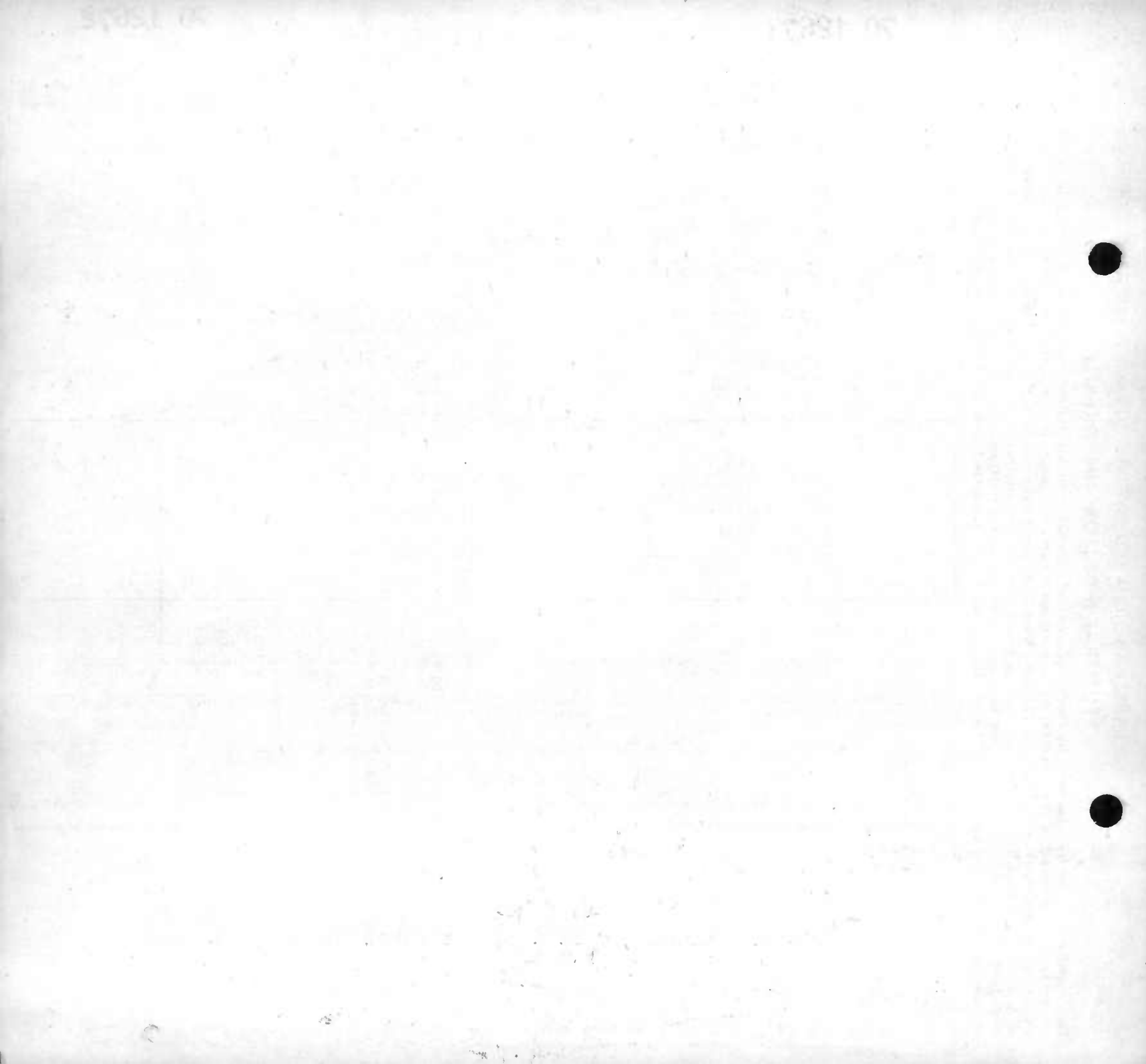
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12672				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12672	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>HOOPER, John</b>				2. DATE AND HOUR OF DEATH <b>12/28/70</b>		7:15 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>704</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>The Johns Hopkins Hospital</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1814 Ashland Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 6 - 1900</b>		9. AGE (In years lost birthday) <b>70</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retail Labor</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Lotter Brown</b>		ADDRESS <b>Same</b>	
18. <b>412.31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Artery Disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary Artery Disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>David J. Driscoll M.D.</b>				23B. DATE SIGNED <b>12/28/70</b>		23C. PHYSICIAN'S NAME (Type) <b>David J. Driscoll M.D.</b>	
23D. ADDRESS <b>The Johns Hopkins Hospital</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12-31-70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Ant. Arundel</b>		24D. LOCATION (City, town, or county) <b>Balto Md</b>		(State)	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>		25C. FUNERAL DIRECTOR <b>Corbison</b>		ADDRESS <b>1000 Brantley Ave</b>	



400 ✓  
DR. SPITZ  
MED EXAM  
NON MED  
FUNERAL DIRECTOR: IMPORTANT  
2789 65  
Veal, Jesse

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12673	
BIRTH NO. 70 12673				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) JESSIE K. VEAL		2. DATE AND HOUR OF DEATH 12-28-70 8:25 PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 806 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1804 N. BROADWAY			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02-07-16	9. AGE (In years last birthday) 54	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Windsor, N.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME THOMAS SMALLWOOD		14. MOTHER'S MAIDEN NAME ELIZABETH		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Joseph Veal 1804 N. Broadway			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) I 199.0 I CAUSE OF DEATH Metastatic Squamous Carcinoma of Unknown Primary APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2.6 mos		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gerald J. Elfenbein MD DEGREE				23B. DATE SIGNED 12/28/70	
23C. PHYSICIAN'S NAME (Type) GERALD J. ELFENBEIN M.D. DEGREE				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-71		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county) Anne Arundel Co., Md.		24E. STATE (State)			
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1970		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Randolph J. Collick 2431 E. Oliver St.	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 12674</b>	
BIRTH NO. <b>70 12674</b>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>LELAND R. FINNEY</b>			2. DATE AND HOUR OF DEATH <b>12-27-70 5:55 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2001</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b> <b>245 N. MONROE ST.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b>		6. RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PORTER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>?</b>		8. DATE OF BIRTH <b>4-24-1900</b> 9. AGE (In years last birthday) <b>70</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JAMES A. FINNEY</b>	
14. MOTHER'S MAIDEN NAME <b>SARAH E. FOSQUE</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>27-058324</b>	
17. INFORMANT <b>Mrs. GLADYS FINNEY</b>		ADDRESS <b>245 N. MONROE ST.</b>		18. CAUSE OF DEATH <b>410.9</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL INFARCTION ?</b>		ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTERIOSCLEROTIC CV DIS. ?</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/27/1970</b> to <b>12/27/1970</b> , that (I) (we) last saw the deceased alive on <b>12/27/1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John S. Braxton</b>		23B. DATE SIGNED <b>12/30/70</b>		23C. PHYSICIAN'S NAME (Type) <b>JOHN S. BRAXTON, M.D.</b>	
23D. ADDRESS <b>3600 PARK HILLS AVE.</b>		23E. ATTENDING PHYSICIAN Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23F. DEGREE <b>M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-31-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>ARBUTUS MEMORIAL PK. ARBUTUS, Md.</b>	
24D. LOCATION (City, town, or county) <b>Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>		24F. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
24G. FUNERAL DIRECTOR <b>Randolph J. Collick</b>		24H. ADDRESS <b>2431 E. Oliver St.</b>		24I. DEGREE <b>M.D.</b>	

1917

June

142 N. Lincoln St.

Wash. D.C.

Dear Sir

James H. Finney

No

Washington

and Baltimore

4-24-1917

Baltimore, Md.

James H. Finney

Address - Mrs. James H. Finney

During the past several years

Myself and others

140 04 23 AS  
W. 425  
WILSON. BERNETTA R.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 12675

BIRTH NO. 70 12675		1. NAME OF DECEASED (Type or Print) BERNETTA R. WILSON		2. DATE AND HOUR OF DEATH 12/28 1970 8:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1825 W. Lanvale Street	
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/13/25	9. AGE (In years last birthday) 45	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY J. H. University		11. BIRTHPLACE (State or foreign country) Balto. MD	
13. FATHER'S NAME Harry Hutchins			14. MOTHER'S MAIDEN NAME Lillian Fowler		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-14-7179		17. INFORMANT Bernetta Wilson 1825 W. Lanvale St	
18. 73411 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SEPTICAEMIA (B) SYSTEMIC LUPUS ERYTHEMATOSUS (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 3 MONTHS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from October 27 1970 to December 28 1970, that (1) (we) last saw the deceased alive on December 28 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James K. Yeung M.D. DEGREE				23B. DATE SIGNED 12/28 1970	
23C. PHYSICIAN'S NAME (Type) James K. Yeung, M.D. DEGREE				23D. ADDRESS Johns Hopkins Hospital, Baltimore Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/31/70		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk. Arbutus MD.	
24D. LOCATION (City, town or county) (State)		25A. DATE REC'D BY HEALTH DEPT. DEC 30 1970			
25B. NAME OF REGISTRAR James E. Yeung M.D.		25C. FUNERAL DIRECTOR Joseph G. Locki		25D. ADDRESS 1304 N. Central Ave	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

GERTHIE WING

2. DATE AND HOUR OF DEATH

12/28/70 5pm

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN  
BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1204 YOUNG COURT APT A-2

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

01-2-85

9. AGE (In years  
last birthday)

85

10. Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Cook

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

220-20-8672

17. INFORMANT

ADDRESS

Catherine Brown 1613 N. Broadway

18. 43391

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Probable cerebral thrombosis

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐Not While ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/22 1970 to 12/28 1970,  
that (I) (we) last saw the deceased alive on 12/28 1970 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Henry D. Ziegler, MD

DEGREE

Attending ☒ Phys.Med. ☐ DirectorStaff ☐ Phys.

23B. DATE SIGNED

12/28/70

23C. PHYSICIAN'S  
NAME (Type)

Henry D. Ziegler, MD

DEGREE

23D. ADDRESS

Johns Hopkins Hospital Baltimore, Md.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

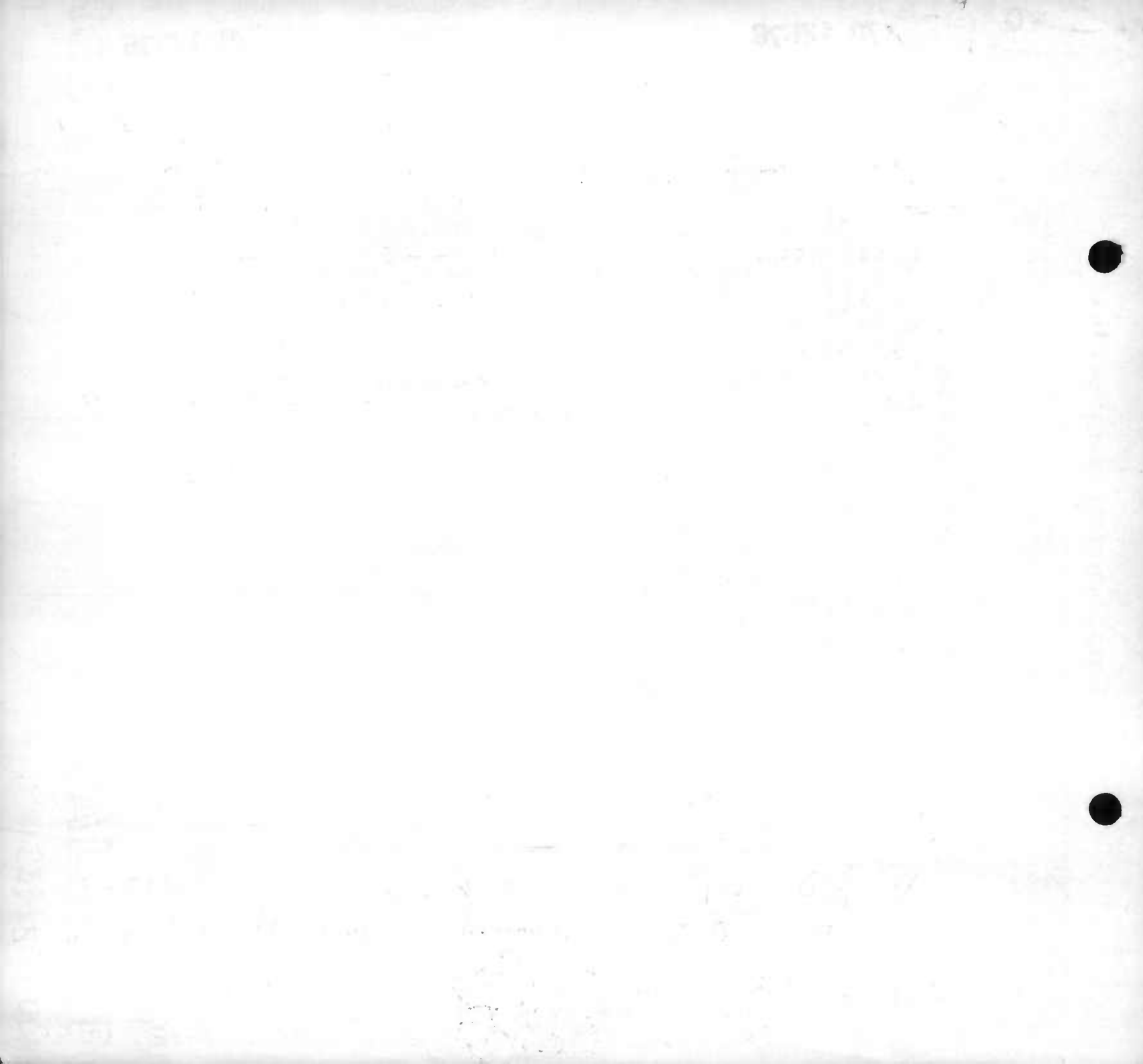
25C. FUNERAL DIRECTOR

ADDRESS

DEC 30 1970

Joseph B. Locks

1304 N. Central Ave



# FUNERAL DIRECTOR: IMPORTANT

proved by the chief medical examiner or his assistant if death occurred in a hospital and he hospital by a medical examiner. Also, if the direct or contributing cause of death was any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased in hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 12677</b>	
BIRTH NO. <b>70 12677</b>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>CHARLES SIMMONS</b>			2. DATE AND HOUR OF DEATH <b>12-28-70 10:30 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 The Johns Hopkins Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, If institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>808</b>		
			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>1014 Lamont Avenue</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/24/07</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>			11. BIRTHPLACE (State or foreign country) <b>Crewe, Va</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Charlie Simmons</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Fitzgerald</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Bernice Johnson 4911 Lanier Ave</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>155.01 UPPER GI BLEED</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			(B) <b>HEPATOMA</b> DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) <b>CHRONIC ETOH</b> <b>1 1/2 yrs</b> <b>40 yrs</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>NONE</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (1) (this hospital) attended the deceased from <b>12-28 1970 7 PM - 10:30 PM</b> , that (1) (we) last saw the deceased alive on <b>12-28 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Steven E. Rubin MD</b>			23B. DATE SIGNED <b>12-28-70</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>STEVEN E. RUBIN</b>			23D. ADDRESS <b>JOHNS HOPKINS HOSP.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1/2/71</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary</b>	24D. LOCATION (City, town, or county) (State) <b>B. &amp; B. County, Md</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR <b>Joseph J. Locke</b>		
		ADDRESS <b>1304 N. Central</b>			



70 12678

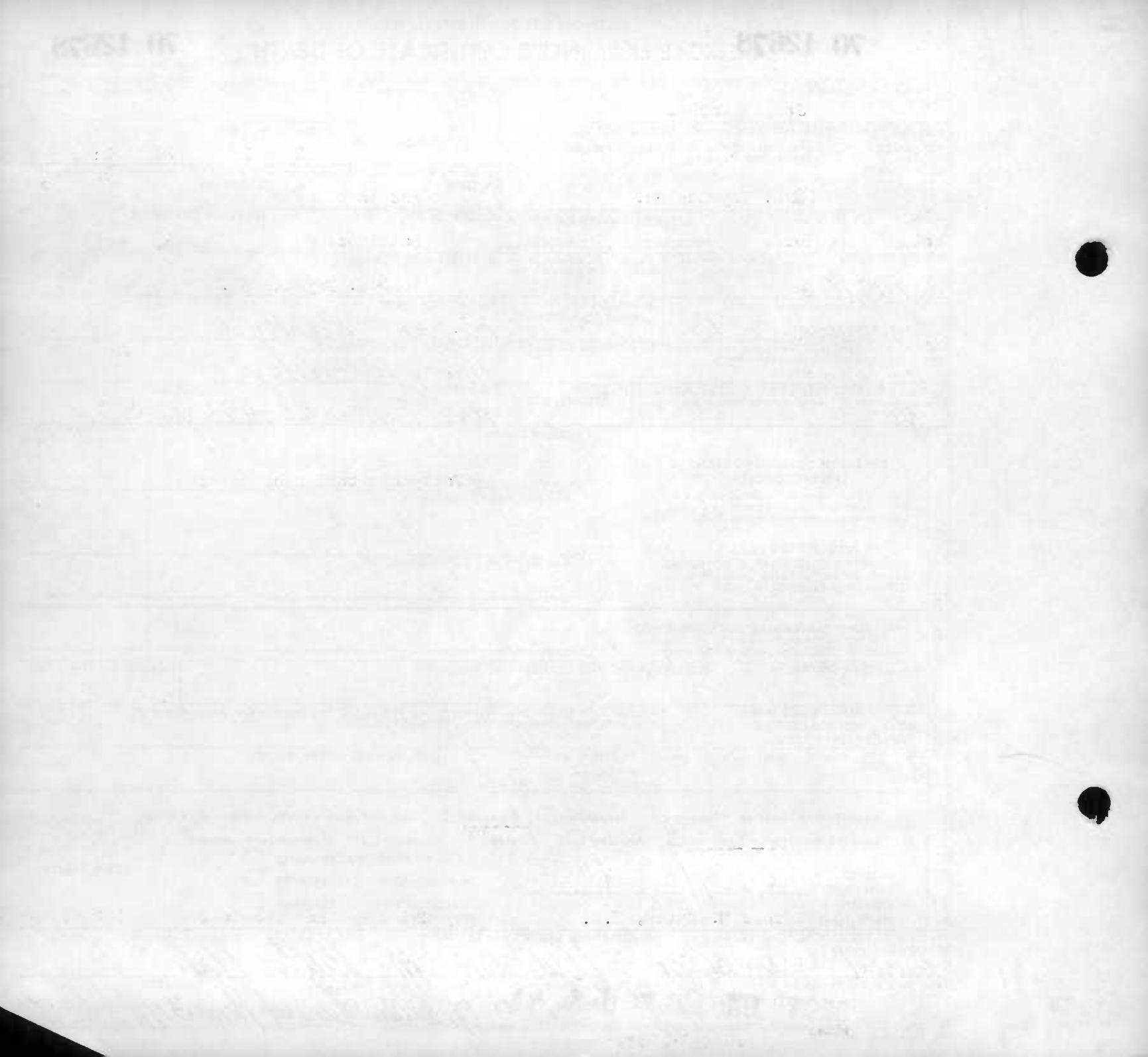
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 12678

BIRTH NO.

1. NAME OF DECEASED (Type or Print) James Parker		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1058 W. Fayette St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 28 70 2:05 p. M.	
6. SEX male		7. RACE colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1802	
9. DATE OF BIRTH Aug. 15, 1926		10. AGE (in years last birthday) 44	
11. BIRTHPLACE (State or foreign country) Accomack Co. Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert Parker		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME Mary E. Bailey		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Ann Parker 2544 Boyd St.	
19. CAUSE OF DEATH 571.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fatty alteration of liver DUE TO, OR AS A CONSEQUENCE OF: (a) IMMEDIATE CAUSE (b) DUE TO, OR AS A CONSEQUENCE OF: (c) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 12/29/70 DATE SIGNED			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 31, 1970	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1970		25B. NAME OF REGISTRAR Robert E. Bailey, R.D.	
25C. FUNERAL DIRECTOR William J. Hone		ADDRESS 3197 So.	



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70 12679

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 12679

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) James W. McEachern (McEachern)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month 12	Day 28	Year 70	Hour 5:15 a.	M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 2646 W. North Avenue		3. DATE PRONOUNCED DEAD		Month 12	Day 28	Year 70	Hour 5:15 a.	M.
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1506		6. SEX male		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 7-8-1941		10. AGE (In years lost birthday) 29		11. BIRTHPLACE (State or foreign country) New York City, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Fred McEachern
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Carrie Belle Powell		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes 8/22/62 8/27/65		17. SOCIAL SECURITY NO.
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes 8/22/62 8/27/65		17. SOCIAL SECURITY NO.		18. INFORMANT Mrs. Loisteen McEachern		ADDRESS 4030 Fairfax Rd.		
19. 571.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes				
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?				
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/28/70								
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-2-71		24C. NAME of CEMETERY or CREMATORY St. Thomas Cemetery		24D. LOCATION (City, town, or county) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR NORTON & DYETT F.H.		ADDRESS 1701 Laurens Street		



70 12680

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12680

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HARRY ALDRIDGE BARNEY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 24 1970 3:10 p.m.</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1301</b>	
6. SEX <b>male</b>	7. RACE <b>negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Balto.</b>
9. DATE OF BIRTH <b>2-17-1949</b>		10. AGE (In years lost birthday) <b>21</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Kershaw Co., South Carolina</b>		12. CITIZEN OF <b>U.S.A.</b>	E. STREET AND NUMBER <b>2439 Callow Ave.</b>
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>C.O.D. Oil Co.</b>	13. FATHER'S NAME <b>Layman Barney (Labin)</b>
15. MOTHER'S MAIDEN NAME <b>Rosa Lee Nettles</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>	
17. SOCIAL SECURITY NO. <b>213-52-4850</b>		18. INFORMANT <b>M's Debbie Barney</b>	
19. CAUSE OF DEATH <b>E9701</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		ADDRESS <b>2439 Callow Avenue</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Arlington &amp; Mosher St. 1601</b>		22D. TIME OF INJURY (APPROX.) Month Day Year <b>12-24-70 ?</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot by policeman.</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12-25-70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12-29-70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park -</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>	ADDRESS <b>1701 Laurens Street</b>

08851 07

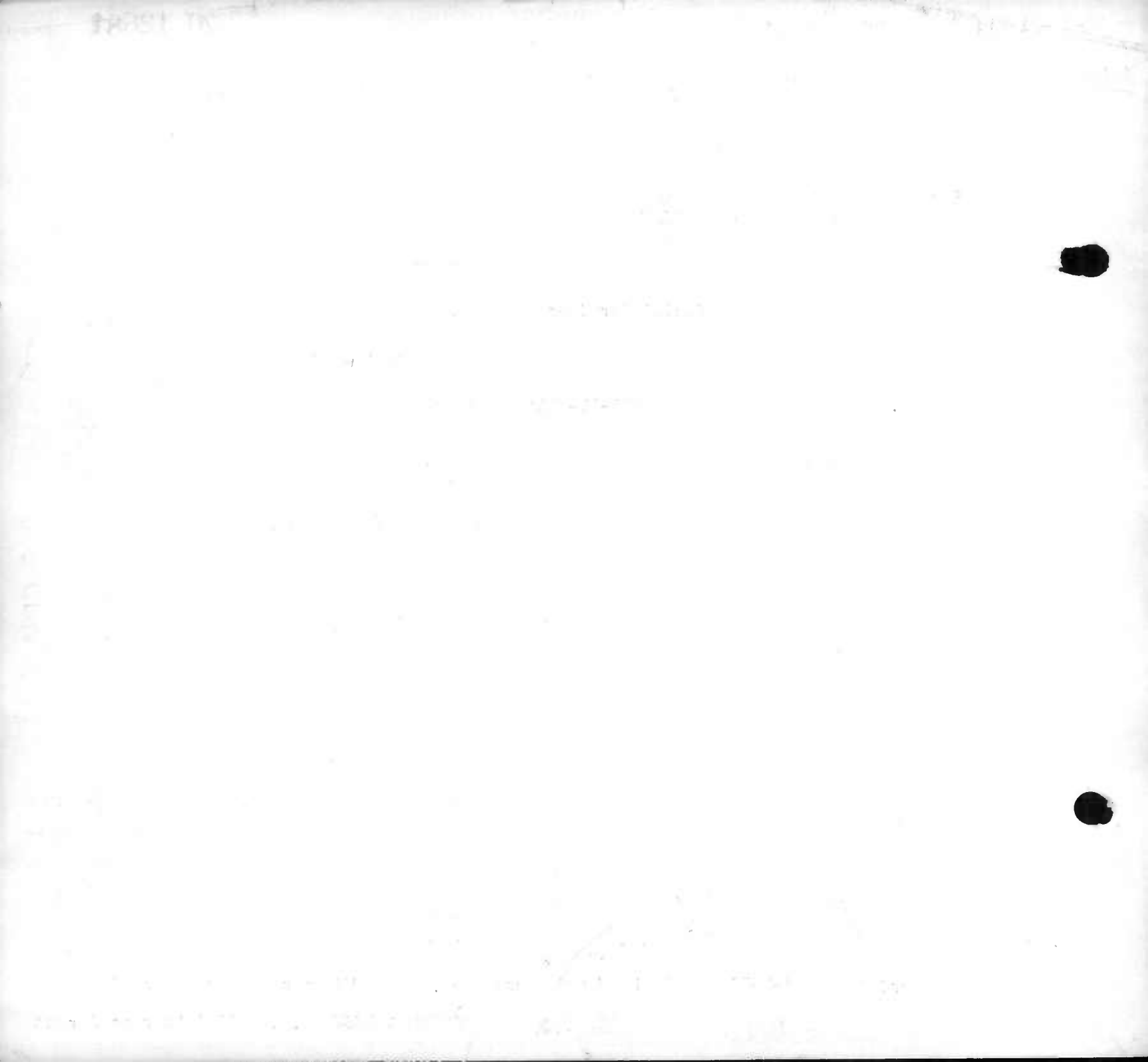
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*[Handwritten signature]*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12681		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 12681	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Smallwood, Theodore</i>		2. DATE AND HOUR OF DEATH <i>December 27, 1970 05:00</i> <span style="float: right;">M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2717</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hospitals</i> <i>1940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Male</i>		6. RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>1-28-27</i>		9. AGE (In years last birthday) <i>43</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Social Services</i>	
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Tommy Smallwood</i>	
14. MOTHER'S MAIDEN NAME <i>Rena Smallwood</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No.</i>		16. SOCIAL SECURITY NO. <i>223-32-0728</i>	
17. INFORMANT <i>4940 Eastern Avenue</i> <i>BCH: Records Baltimore, Maryland 21224</i>		18. <i>446.5 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) <i>Cardiorespiratory arrest</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Thrombotic Thrombocytopenic Purpura</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Status Post-Splenectomy</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>acute</i> <i>3 days</i> <i>6 hrs.</i>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (N) (this hospital) attended the deceased from <i>December 25</i> 19 <i>70</i> to <i>December 27</i> 19 <i>70</i> that (N) (we) last saw the deceased alive on <i>Dec. 27</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (N) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Francisco Tejada M.D.</i>				23B. DATE SIGNED <i>Dec. 27, 1970</i>	
23C. PHYSICIAN'S NAME (Type) <i>Francisco Tejada M.D.</i>				23D. ADDRESS <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue Baltimore, Maryland 21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-2-71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Indian Wood Church Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Windsor, North Carolina</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 30 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Jarboe, M.D.</i>	
25C. FUNERAL DIRECTOR <i>MORTON &amp; DYETT F.H.</i>		25D. ADDRESS <i>1701 Laurens Street</i>			



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## BALTIMORE CITY HEALTH DEPARTMENT

70 12682

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 12682

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Gloria C. Brown		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 12 27 70 4:20 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 27 70 4:20 p.m.	
6. SEX female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 12-11-1933		10. AGE (in years last birthday) 37	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herman Medley		14. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1506	
15. MOTHER'S MAIDEN NAME Elva Medley		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) No.	
17. SOCIAL SECURITY NO. 217-24-4208		18. INFORMANT Mr. Warrington Brown	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple injuries with massive internal hemorrhage (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Intersection of Baker and Payson Streets 1502	
22D. TIME OF INJURY (APPROX.) 12 13 70 9:25		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Subject was a passenger in auto-auto collision.		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 12/28/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-31-70	
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1970		25B. NAME OF REGISTRAR Robert E. Gabry, R.D.	
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens Street	

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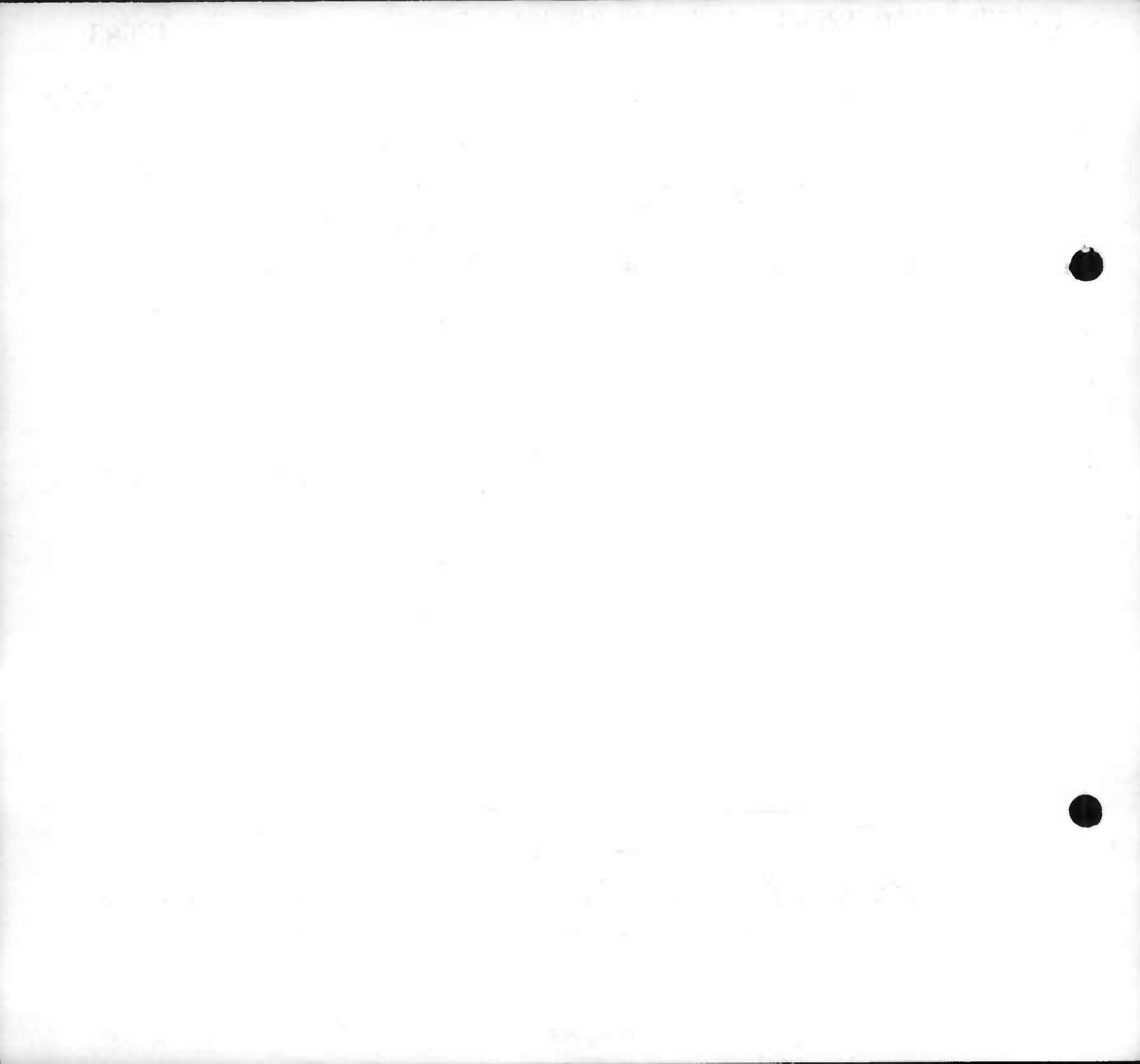
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12683		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 12683	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>RUTH B. BAKER</b>			2. DATE AND HOUR OF DEATH <b>DEC. 28, 1970 1240 P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1601</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>1032 EDMONDSON AVE.</b>		
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/17/96</b>	9. AGE (In years last birthday) <b>74</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13. FATHER'S NAME <b>Silas Bailey</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Woods</b>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>218-58-3804</b>	17. INFORMANT <b>Mr. Herbert Baker</b>		ADDRESS <b>1032 Edmondson Ave</b>
18. <b>436671</b> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CEREBROVASCULAR ACCIDENT - PRESUMED</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 DAYS</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) _____ (C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>MYOCARDIAL INFARCTION</b> <b>MYOCARCINOMA OF BREAST - RESECTED 1967</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>	
22. I certify that (1) (this hospital) attended the deceased from <b>Dec. 23 1970</b> to <b>Dec 28 1970</b> that (1) (we) last saw the deceased alive on <b>DEC. 28 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Charles I. Werner, M.D.</b>				23B. DATE SIGNED <b>12/28/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>CHARLES I. WERNER M.D.</b>				23D. ADDRESS <b>UNIV. HOSP.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/2/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Cemetery</b>	
24D. LOCATION <b>Balto.</b>		24E. CITY, TOWN, OR COUNTY <b>Maryland</b>		24F. STATE <b>Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Faber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Morton S. Dyett F.H. 1701 Laurels St.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12684</u>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <u>70 12684</u></span> <span>CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print) <u>Murphy Ernest</u>			2. DATE AND HOUR OF DEATH <u>12-27-70</u> <u>7 P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2543</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>South Balto. General</u> <u>43 Hqs. Baltimore</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>M</u> 6. RACE <u>N</u>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-3-08</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>62</u>
13. FATHER'S NAME <u>NEAL Murphy</u>			14. MOTHER'S MAIDEN NAME <u>Minnie Pipkins</u>		11. BIRTHPLACE (State or foreign country) <u>South Caroling</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO.</u>			16. SOCIAL SECURITY NO. <u>240-20-0081</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
17. INFORMANT <u>Mrs. Lannie Murphy</u>			ADDRESS <u>2631 Puget St.</u>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
I <u>Metastatic Disease</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
II <u>Adenocarcinoma of Prostate</u> (B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-27-70</u> 19 <u>70</u> to <u>12-27</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>12/27</u> 19 <u>70</u> and that <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>C. Carter M.D.</u>				23B. DATE SIGNED <u>12/27/70</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/31/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Carver Mem. Park</u>	
24D. LOCATION <u>Laurel</u>		24E. (City, town, or county) <u>Maryland</u>		24F. (State) <u>Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Horton &amp; Dyett F.H.</u>	
25D. ADDRESS <u>1701 Laurens St.</u>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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70 12685

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

70 12685

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Chestina Belle Perry  
Belle C. Perry

2. DATE AND HOUR OF DEATH

Dec. 26, 1970, 4:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospital  
4940 Eastern Ave. Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

801 Bay St.

005

5. SEX

Female

6. RACE

Black

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

10-06-05

9. AGE (In years last birthday)

65

10. Under 1 Yr. Months Days

11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

XXXXXXXX Charlotte Court House Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Reginald Johnson

14. MOTHER'S MAIDEN NAME

Laura Reid

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

17. INFORMANT

4940 Eastern Ave.

ADDRESS

BCH Records: Baltimore, Md. 21224

18. 250.01

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Amoebic 2<sup>nd</sup> to carcinoma

(B) DUE TO, OR AS A CONSEQUENCE OF:

Diabetic ketoacidosis & sepsis

(C) DUE TO, OR AS A CONSEQUENCE OF:

Diabetes mellitus

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (A).

ASCVD

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec. 23, 1970 to Dec. 26, 1970 that (I) (we) last saw the deceased alive on Dec. 26, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. L. Fleg M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

12/26/70

23C. PHYSICIAN'S NAME (Type)

J. L. Fleg M.D.

23D. ADDRESS

4940 Eastern Ave. Baltimore, Md. c/o Baltimore City Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-31-70

24C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cemetery

24D. LOCATION (City, town, or county)

A.A. Co.,

(State)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

DEC 30 1970

25B. NAME OF REGISTRAR

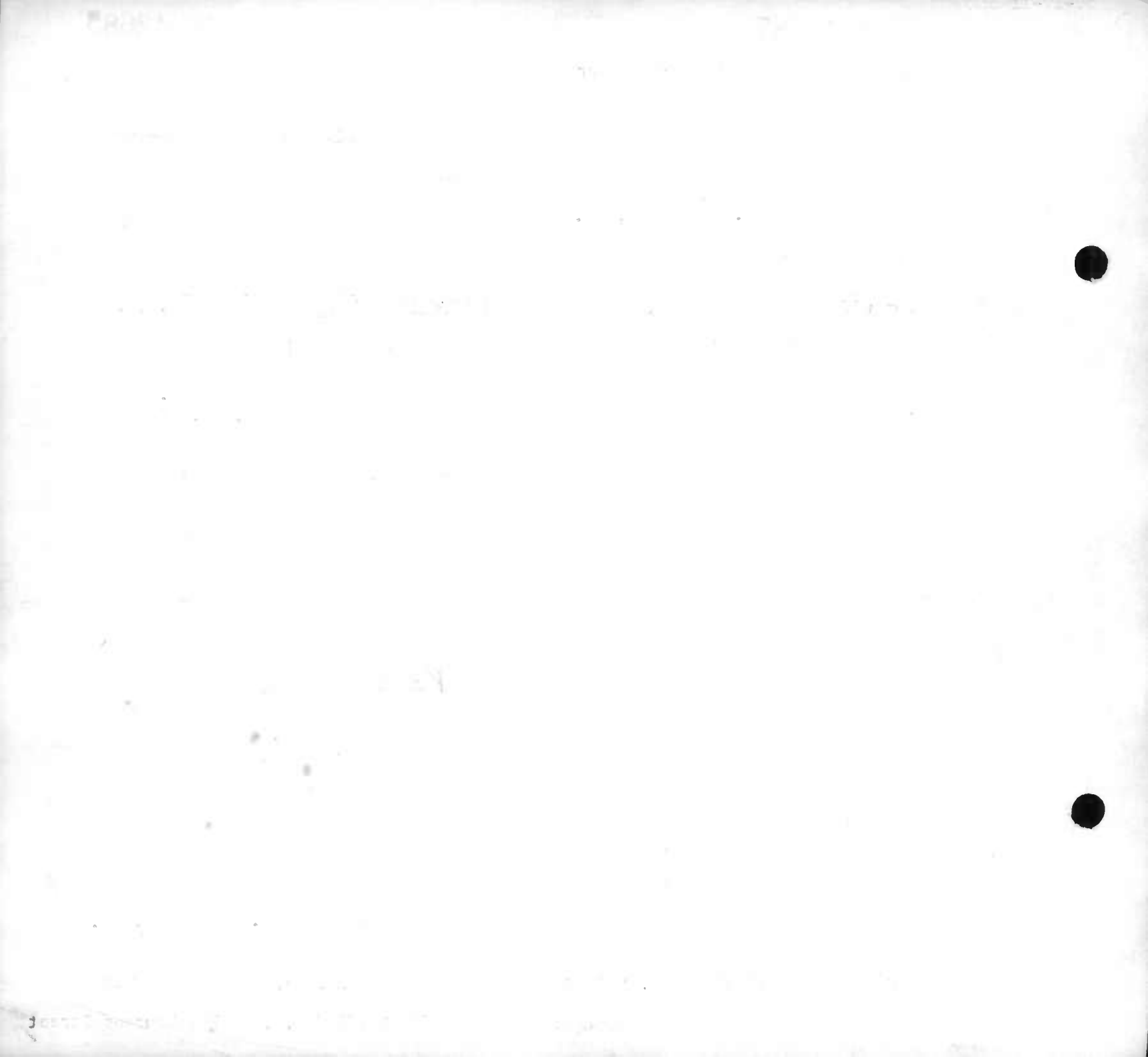
Robert E. Faber, M.D.

25C. FUNERAL DIRECTOR

MORTON & DYETT F.H.

ADDRESS

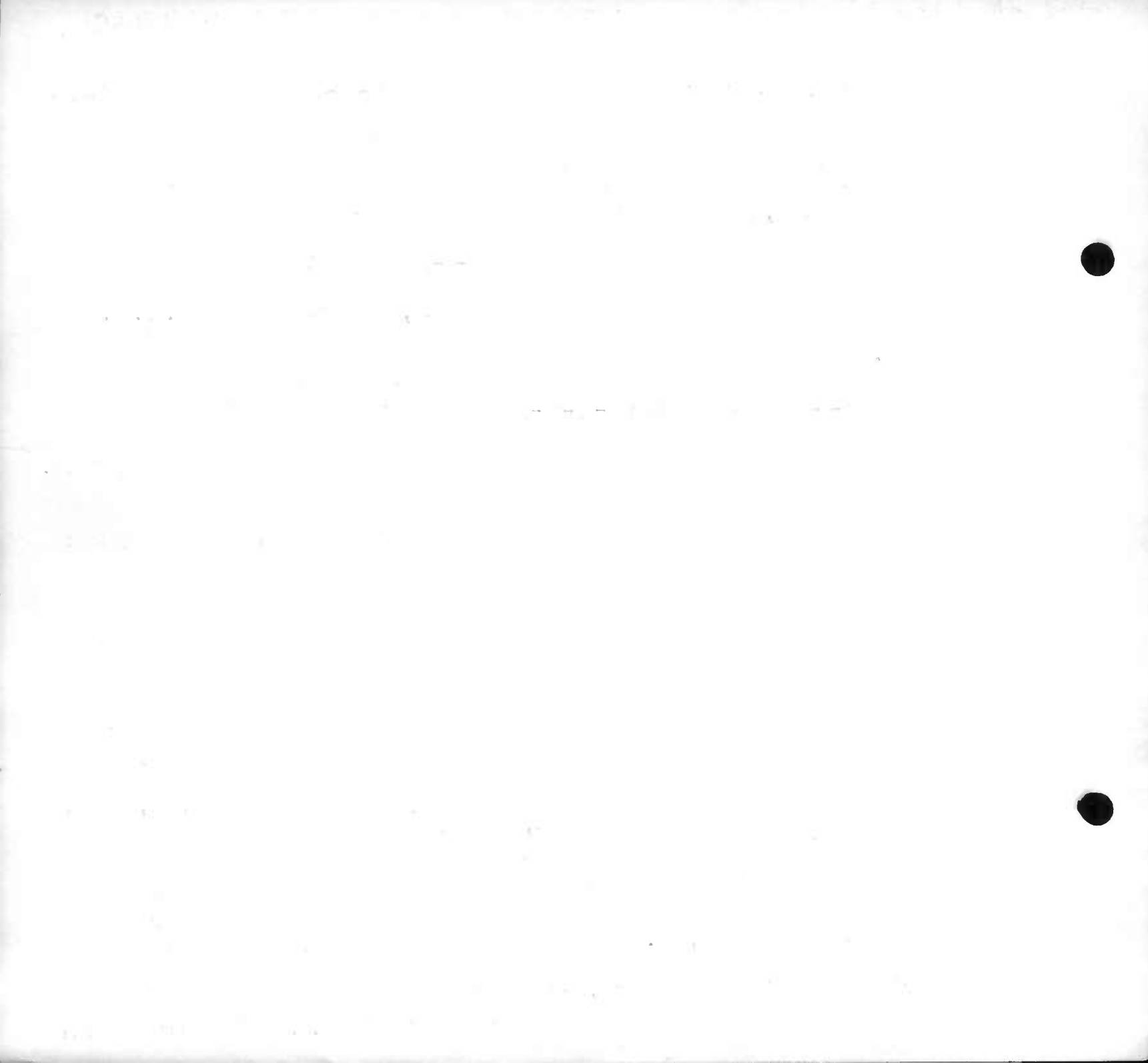
1701 Laurens Street



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 70 12686		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 12686	
1. NAME OF DECEASED (Type or Print) <b>YOUNG, John Robert</b>			2. DATE AND HOUR OF DEATH <b>12-27-70 12:05 A. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>			4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) A. STATE <b>Pennsylvania</b> B. COUNTY <b>V-35</b> C. CITY OR TOWN <b>Clairton</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>447 Park Avenue</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12-2-98</b>	9. AGE (in years last birthday) <b>72</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Suffolk, Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>John E. Young</b>		
14. MOTHER'S MAIDEN NAME <b>Anna Bland</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 3-1-17 to 6-19-19</b>		
16. SOCIAL SECURITY NO. <b>193-03-15-93</b>			17. INFORMANT VA Hospital Records <b>Baltimore, Maryland 21218</b>		
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Lung, Right</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Congestion and Edema of Lungs, Moderate</b> (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Pneumonia</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 Years.</b> <b>3 Days</b> <b>3 Days</b>		
19A. DATE OF OPERATION <b>12-27-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>JO</b> (this hospital) attended the deceased from <b>November 12</b> , 19 <b>70</b> to <b>December 27</b> , 19 <b>70</b> that <b>HE</b> (we) last saw the deceased alive on <b>December 27</b> , 19 <b>70</b> and that in <b>MY</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>JO</b> (We) (did) <b>NOT</b> view the body after death.					
23A. SIGNATURE <b>Jaime F. Casellas, M.D.</b>			23B. DATE SIGNED <b>12-27-70</b>		23C. PHYSICIAN'S NAME (Type) <b>Jaime Casellas, MD.</b>
23D. ADDRESS <b>3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>		24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>12-30-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>	
25D. ADDRESS <b>1701 Laurens Street</b>					



Released on approval by medical examiner 23 December 1970. Fatih Salih Zada, M.D.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12687		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12687	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CASSIDY Mary G.</b>		2. DATE AND HOUR OF DEATH <b>29 December 1970 11.50 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1202</b>		C. CITY OR TOWN <b>Baltimore Md 21218</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b> <b>33 rd and Calvert Streets Baltimore Md 21218</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>3003 Charles Street</b>	
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>07-26-87</b>	9. AGE (In years last birthday) <b>83</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA (American)</b>		13. FATHER'S NAME <b>James J. Cassidy</b>		14. MOTHER'S MAIDEN NAME <b>Florence Carlin</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>medical record, Union Memorial Hospital</b> <b>33 rd and Calvert Streets, Baltimore Md 21218</b>	
18. <b>410.9 4-2-88</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary occlusion</b>		<b>1 hour</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Arterial sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF:			
(C) <b>Fracture of Right hip and Austin Moore prosthetic operation</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>22 December 1970</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fracture of Right hip</b>		20A. AUTOPSY? (Yes or No) <b>=</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>3003 Charles Street, Homewood Apt D, Baltimore 21218</b>	
21D. TIME OF INJURY (APPROX.) <b>12 20 1970, night</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fell in Home</b> <b>3003 Charles St</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>21 December 1970</b> to <b>29 December 1970</b> that (I) (we) last saw the deceased alive on <b>29 December 1970</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X)</b> (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>Fatih Salih Zada, M.D.</b>		23B. DATE SIGNED <b>29 December 1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>FATIH SALIH ZADA M.D.</b>		23D. ADDRESS <b>Union Memorial Hospital</b> <b>Baltimore Maryland 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-2-1971</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Road Balto., Md. 21212</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12688		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X	REG. NO. 70 12688
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BAUER, WILLIAM R		DECEMBER 29, 1970 3:30P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  40 ST. AGNES HOSPITAL		A. STATE PENNSYLVANIA			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN PITTSBURGH		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 880 NO MEADOWCROFT AVE			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04/21/08	9. AGE (In years last birthday) 62	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED-SALES		10B. KIND OF BUSINESS OR INDUSTRY A.A.I. Corp.		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
13. FATHER'S NAME J. WILLIAM BAUER		14. MOTHER'S MAIDEN NAME MARTHA (FITZSIMMONS) BAUER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 167-01-0485		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS	
18. 423X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: with perforation - (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Pericarditis - Prob. Liver Cirrhosis			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (the) (this hospital) attended the deceased from NOVEMBER 29 1970 to DECEMBER 29 1970 that (we) last saw the deceased alive on DECEMBER 29 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE  DR. S. QUIROZ		23B. DATE SIGNED 12/29/70		23C. PHYSICIAN'S NAME (Type) DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Rem. Burial		24B. DATE 1/4/71		24C. NAME of CEMETERY or CREMATORY Uniondale	
24D. LOCATION (City, town, or county) (State) Pittsburgh, Pa.		25A. DATE REC'D BY HEALTH DEPT. DEC 30 1970			
25B. NAME OF REGISTRAR R. E. Jenkins, M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4205 York Rd. Balto., Md. 21212			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>70 12689</b>	
BIRTH NO. <b>70 12689</b>				CERTIFICATE OF DEATH	
M.E. CASE NO. <b>20-32758</b>				1. NAME OF DECEASED (Type or Print) <b>MICHAEL SHAWN SKILES</b>	
2. DATE AND HOUR OF DEATH <b>December 28, 1970 7<sup>00</sup> A M.</b>				3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION <b>md. Gen. Hosp.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>1206</b> D. STREET ADDRESS (If rural, give location) <b>2709 N. HOWARD ST. 21218</b>	
5. SEX <b>male</b>		6. RACE <b>white</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>N.B.</b>	
8. DATE OF BIRTH <b>DEC 26, 1970</b>		9. AGE (In years last birthday) <b>1 7 30</b>		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>md</b>	
13. FATHER'S NAME <b>WAITER MARTIN MULLIGAN</b>				14. MOTHER'S MAIDEN NAME <b>CAROL VIRGINIA SKILES</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>mother</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>226.91</b>		CAUSE OF DEATH <b>Pneumonia? pulmonary Reg. failure Consolidation</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12/28/70</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <b>Pulmonary atelectasis</b>		(B) DUE TO <b>for Regime Mon. dis.</b>	
(C) DUE TO		(D) DUE TO		(E) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>DEC 26</b> 19 <b>70</b> to <b>DEC 28</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>DEC 28</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Elallop B.</b>				23B. DATE SIGNED <b>12/28/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Boonprakong-Vallop</b>				23D. ADDRESS <b>M.D. Maryland General Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/29/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 31 1970</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>John A. Moran, Inc.</b>			
25D. ADDRESS <b>3000 E. Baltimore St. Baltimore, Md. 21224</b>		25E. ADDRESS <b>3000 E. Baltimore St. Baltimore, Md. 21224</b>			

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Handwritten notes and signatures, including a large signature at the bottom center and several lines of text above it.

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70 12690

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12690

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Lambert Ward

2. DATE  
OF  
DEATHKnown ☒  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

3901 Walnut Ave.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

12

26

70

9:30 a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

male

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

1-5-1880

10. AGE (in years  
last birthday)

90

If Under 1 Yr. II Under 24 Hrs.

Months

Days

Hours

Min.

E. STREET AND NUMBER

3901 Walnut Ave.

11. BIRTHPLACE (State or foreign country)

Calvert Co., Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

David A. Ward

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Painter Ret.

14B. KIND OF BUSINESS OR INDUSTRY

Painting Own

15. MOTHER'S MAIDEN NAME

Elizabeth Johnson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

219-01-7131

18. INFORMANT

ADDRESS

Albert Ward 3901 Walnut Ave. Balto. Md. 21236

19. 412.4

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)22E. INJURY OCCURRED  
WHILE AT ☐  
WORKNOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

Deputy Chief Medical Examiner

DATE SIGNED

12/26/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12-29-70

24C. NAME OF CEMETERY or CREMATORY

Woodlawn Cemetery

24D. LOCATION (City, town, or county)

Baltimore

Maryland

25A. DATE REC'D BY HEALTH DEPT.

DEC 31 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

7401 Belair Rd.  
Balto. Md. 21236

00351 IN

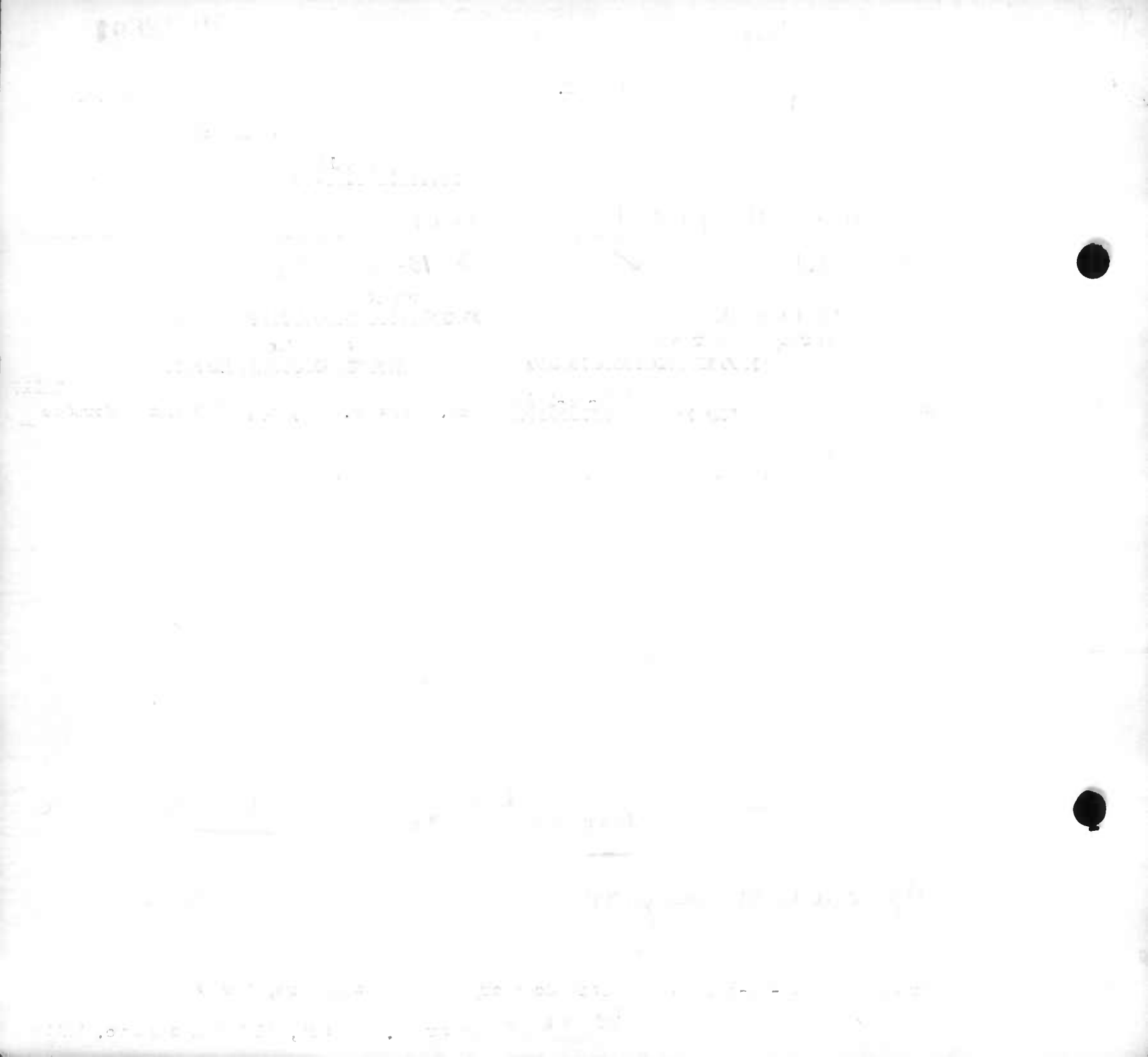
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# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <b>70 12691</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <b>70 12691</b>	
1. NAME OF DECEASED (Type or Print) <b>Burgoon, Howard I.</b>			2. DATE AND HOUR OF DEATH <b>12-28-70 1:45 a.m.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Sinai Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>		
5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			C. CITY OR TOWN <b>ARBUTUS</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER <b>1217 Leeds Terrace</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>			8. DATE OF BIRTH <b>3-10-96</b> 9. AGE (In years last birthday) <b>74</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Harvey Burgoon</b>			14. MOTHER'S MAIDEN NAME <b>Emma Frock</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>212-03-3451</b>		
17. INFORMANT <b>Mrs. Zelma F. Shipley, 1217 Leeds Terrace</b>			ADDRESS <b>21227</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>410.91</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>cardiac arrest seconds</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>complete heart block hours</b> (C) <b>Myocardial infarction hours</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. CAUSE OF DEATH (Notify medical examiner if contributing)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 26</b> 19 <b>70</b> to <b>Dec 28</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>Dec 28</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Marcia Watenburg, M.D.</b>				23B. DATE SIGNED <b>12-28-70</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
<b>Burial</b>		<b>12-30-1970</b>		<b>Loudon Park Cemetery</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<b>DEC 31 1970</b>		<b>Robert E. Taylor, R.D.</b>		<b>Howard H. Hubbard</b>	
				ADDRESS <b>4107 Wilkens Ave. 21229</b>	



N 5501

70 12692

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

70 12692

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO. <u>70-23029</u>		DATE AND HOUR OF DEATH <u>DECEMBER 27, 1970</u> <u>3:00 A.M.</u>	
1. NAME OF DECEASED (Type or Print) <u>NEWMAN, BABY BOY</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>ST AGNES HOSPITAL</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>MALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <u>5136 WESTLAND BLVD</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH <u>12/27/70</u> 9. AGE (In years last birthday) <u>1</u> If Under 1 Yr. Months Days If Under 24 Hrs. Min. <u>28</u>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>JOSEPH P. NEWMAN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>MARY S. SIPES</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>BALTO MD21229</u> ADDRESS <u>ST AGNES' RECORDS CATON &amp; WILKENS AVES</u>	
18. <u>75-3,11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>PREMATURITY, MULTI-</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>PLE EXTERNAL MALFORMATIONS,</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>POLYCYSTIC KIDNEYS BILATERAL</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>DECEMBER 27</u> 19 <u>70</u> to <u>DECEMBER 27</u> 19 <u>70</u> that <u>(X)</u> (we) last saw the deceased alive on <u>DECEMBER 27</u> 19 <u>70</u> and that in <u>(X)</u> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) <u>(X)</u> (not) view the body after death.			
23A. SIGNATURE <u>J. Garcia</u>		23B. DATE SIGNED <u>12-27-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>JORGE F. GARCIA</u>		23D. ADDRESS <u>ST. AGNES HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-29-70</u>	
24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 31 1970</u>		25B. NAME OF REGISTRAR <u>Robt. E. Fisher, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>		ADDRESS <u>4107 Wilkens Ave, 21229</u>	

1. 1000

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B6251

70 12693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

70 12693

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM F. BERGUND

2. DATE AND HOUR OF DEATH

December 24, 1970

5:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Gould Convalesarium Home  
6116 Belair Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN  
Baltimore

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

2512 Taylor Avenue

5. SEX

Male

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

7-20-1879

9. AGE (In years lost birthday)

91

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.  
217-03-2223

17. INFORMANT

ADDRESS 21227

Mr. Edmund Nettleship, 1103 Flamingo Dr.

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

days

months

months

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/27/1970 to 12/24/1970 that (I) (we) lost saw the deceased alive on 12/24/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Albert Bradley

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

12/28/70

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

4900 Belair Road, Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-28-70

24C. NAME of CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

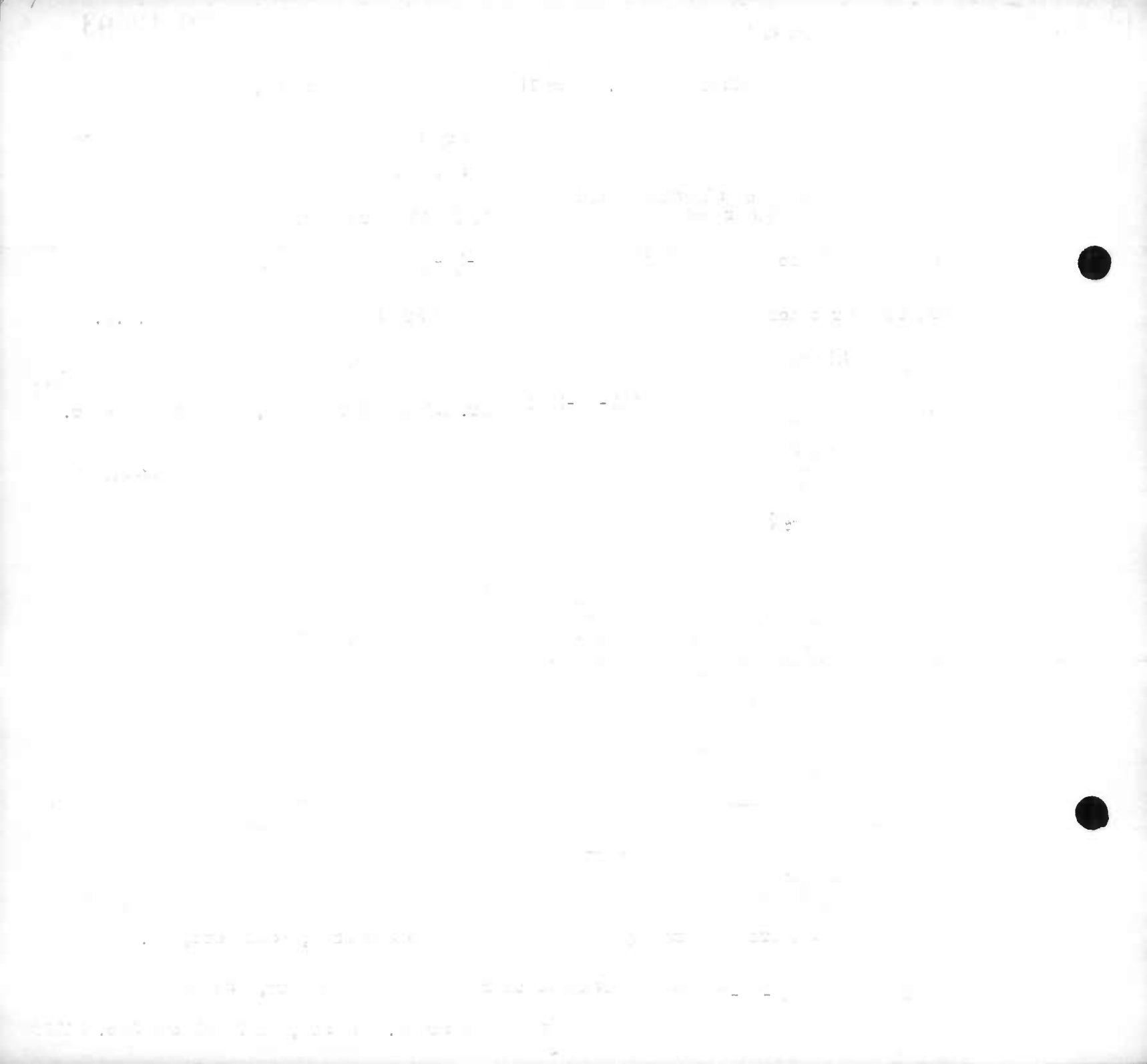
DEC 31 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Ave. 21229



FUNERAL DIRECTOR: IMPORTANT

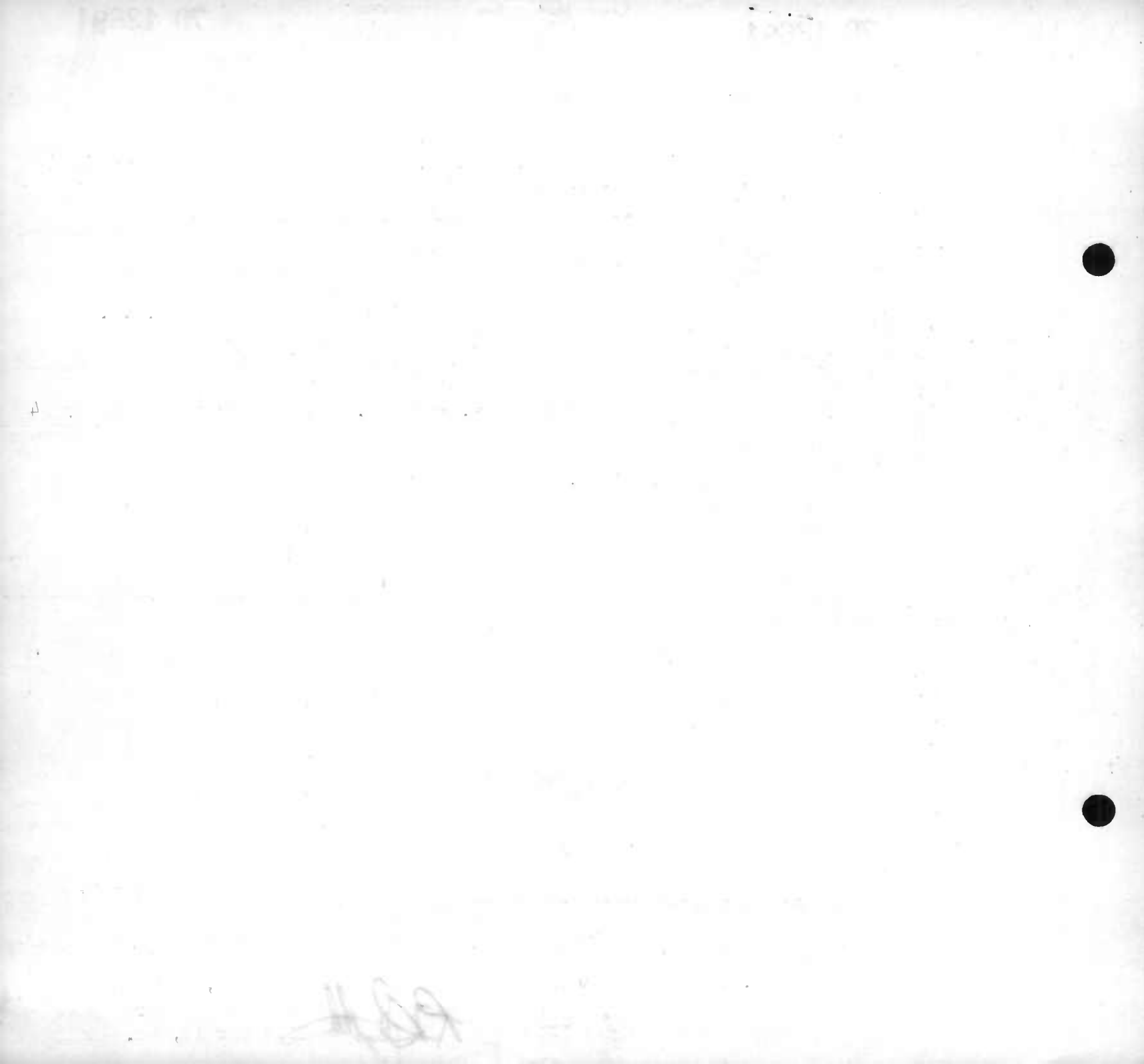
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12694

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 12694

BIRTH NO. 70 12694		1. NAME OF DECEASED (Type or Print) <b>ELMER WITHROW</b>		2. DATE AND HOUR OF DEATH <b>12/25/70 1640 pm M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>AA</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>Rt. 3 Box 115A 5200</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>09-03-49</b>	9. AGE (In years last birthday) <b>21</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Cleaning</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Harry Withrow</b>			14. MOTHER'S MAIDEN NAME <b>Janice Loudermilk</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>214 54 8993</b>		17. INFORMANT <b>Mr. Harry L. Withrow (father)</b> Same As # <b>1</b>
18. CAUSE OF DEATH <b>582X I</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CONGESTIVE FAILURE</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) <b>CHRONIC RENAL FAILURE</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/24</b> 19 <b>70</b> to <b>12/25</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>12/25</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>A. Jackson</b>				23B. DATE SIGNED <b>12/25/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>ANTHONY JACKSON</b>				23D. ADDRESS <b>MEDICAL INTERN JOHNS HOPKINS HOSP</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Dec. 29/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 31 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Singleton Funeral Home</b>	
				ADDRESS <b>Glen Burnie, Md.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12693		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 12693	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JUBB, CHARLES M.</b>		2. DATE AND HOUR OF DEATH <b>12-28-70 10:47 P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>AA</b>		C. CITY OR TOWN <b>LINTHICUM</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>43 SO. BALTIMORE GENERAL HOSPITAL</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER <b>697 W. MAPLE RD. 5200</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-19-04</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MARINE ENGR.</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>ANDREW JUBB</b>		14. MOTHER'S MAIDEN NAME <b>MINNIE LEWIS</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-12 2709-A</b>		17. INFORMANT <b>JOHANNA JUBB - AS ABOVE</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		(A) IMMEDIATE CAUSE <b>CARCINOMA OF LUNG.</b> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-20-70</b> 19 <b>70</b> to <b>12-28</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>12-28</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Michael J. Enley, M.D.</b>		23B. DATE SIGNED <b>12-28-70</b>		23C. PHYSICIAN'S NAME (Type) <b>Michael J. Enley, M.D.</b>	
23D. ADDRESS <b>Raymond C. Fink</b>		23E. FUNERAL DIRECTOR <b>Raymond C. Fink</b>		23F. ADDRESS <b>Glen Burnie, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/31/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Park</b>	
24D. LOCATION <b>Glen Burnie, Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>DEC 31 1970</b>		24F. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>	
24G. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>		24H. FUNERAL DIRECTOR <b>Raymond C. Fink</b>		24I. ADDRESS <b>Glen Burnie, Md.</b>	



70 12696

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12696

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

STEPHENS

Gertrude Stevens

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

F. NAME (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET

HOSPITAL OR INSTITUTION ADDRESS OR LOCATION)

1-13-71

City Hospitals

2-8-71

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

12

26

70

9:45 p

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Pennsylvania

6. SEX

female

7. RACE

white

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Penn Run  
Scranton

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

July 20, 1906

10. AGE (In years  
last birthday)

64

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

8207 DunDalk Ave.

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert Holmes

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Nurse

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Ida McCullough

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

199-30-7492

18. INFORMANT

Bell Funeral Home 200 S. 7th St.

ADDRESS  
Indiana Pa.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)22E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
m. WORK AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Deputy Chief Medical Examiner

12/27/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

24B. DATE

12/28/70

24C. NAME OF CEMETERY or CREMATORY

Harmony Cemetery

24D. LOCATION (City, town, or county) (State)

Indiana, Pa.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

DEC 31 1970

Robert E. Talley, M.D.

Robert C. Altenburg Funeral Home, Inc.

6009 Harford Rd. Balto., Md. 21214

Letter from M.E.'s office  
Letter from M.E.'s office

1-13-71  
2-8-71

M.H.  
M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12697		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 12697	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Joan M. Jones		9:00 AM 12/27/70		9:00 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
Maryland General Hospital		Maryland C. CITY OR TOWN D. INSIDE CITY LIMITS?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER		2757	
7006 Harford Rd					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	01/14/33	37	U.S.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Glenn Collins		Gladys Hughes			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		213-30-1359		Nayland D. Jones - 7006 Harford Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (At stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				yes	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 12/14 1970 to 12/27 1970 that (I) (we) last saw the deceased alive on 12/27 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Michael A. Silverman MD		12/27/70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Michael A. Silverman		Maryland General Hospital Md.			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12/30/70		Meadowridge Cemetery	
24D. LOCATION		24E. LOCATION		24F. LOCATION	
Baltimore		Baltimore		Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 31 1970		Robert E. Faby		Robert C. Altenburg Funeral Home, Inc.	
				6009 Harford Rd. - Balto. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

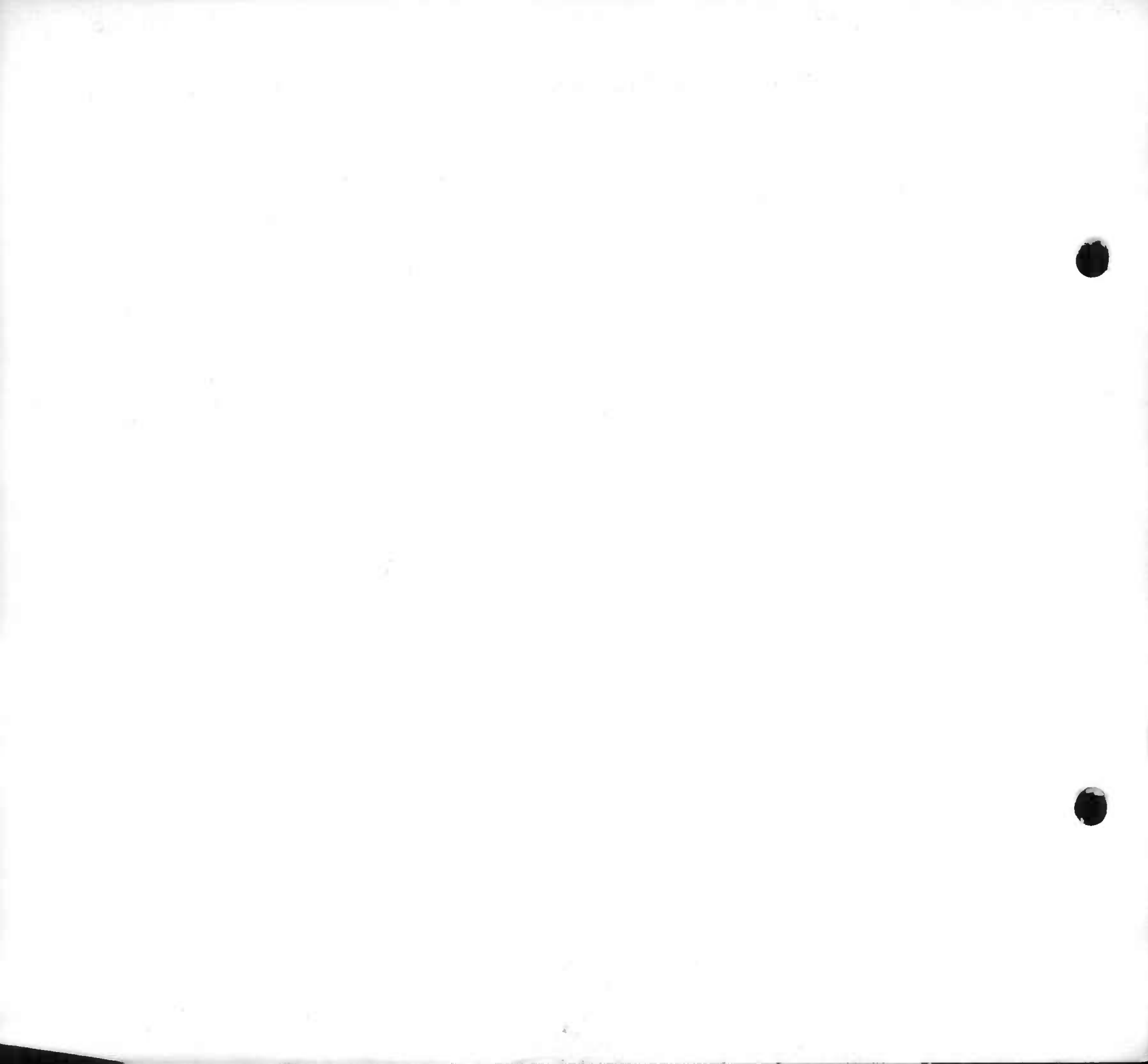
R0001

70 12698

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 12698

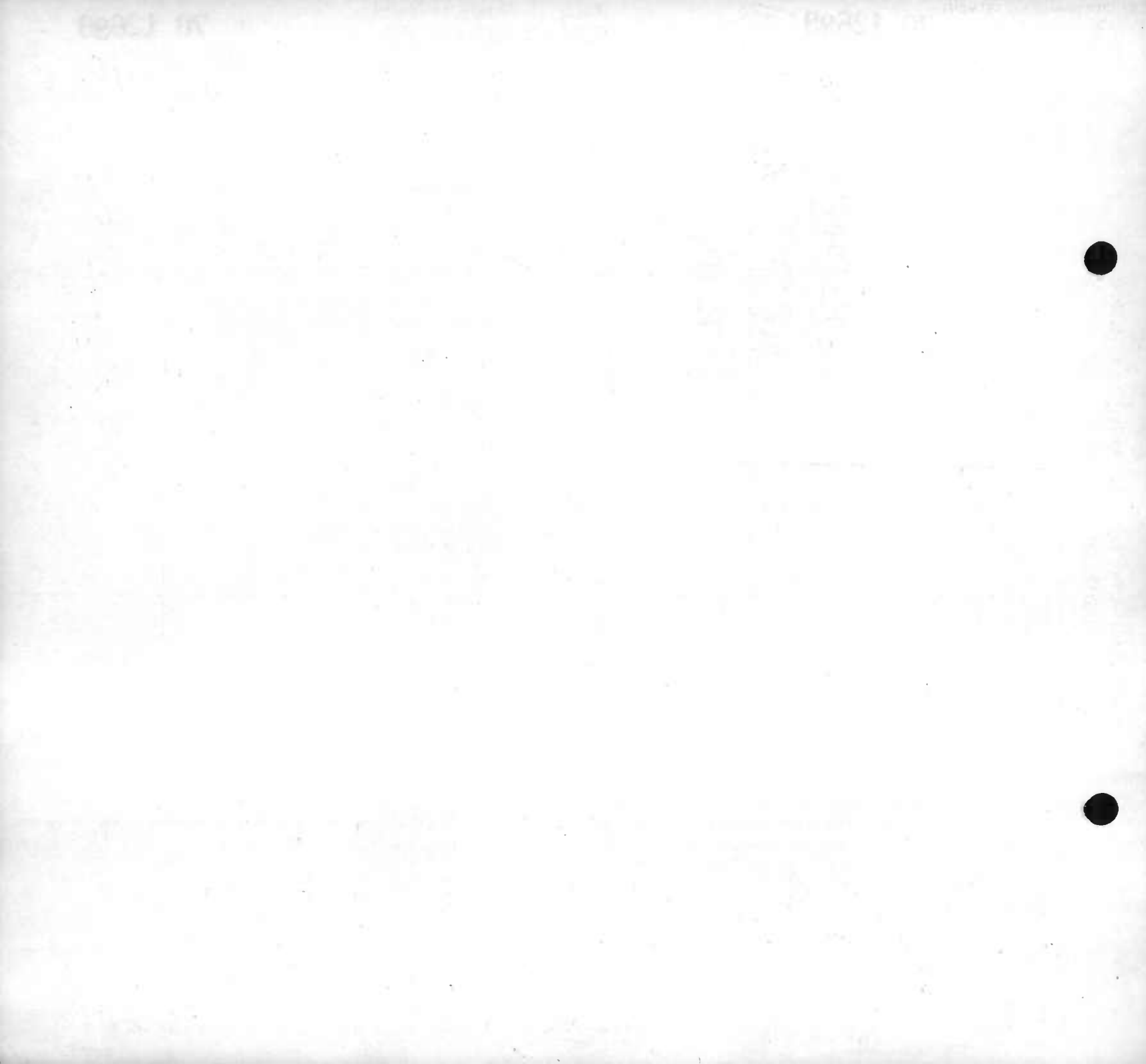
BIRTH NO. 70 12698		2. DATE AND HOUR OF DEATH 12/28/70 @ 4:35 AM M.	
1. NAME OF DECEASED (Type or Print) RAY, MARION		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2636	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3 Johns Hopkins Hosp.		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/12/95 9. AGE (in years last birthday) 75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery trade		11. BIRTHPLACE (State or foreign country) Baltimore U.S.A.	
10B. KIND OF BUSINESS OR INDUSTRY Fruit and Produce		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH RAY		14. MOTHER'S MAIDEN NAME Catherine	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216 324854A	
		17. INFORMANT Barbara RAY 1235 Rayleigh Way ADDRESS	
18. 593.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST (B) RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CARDIAC FAILURE / PUL. FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/27/70 to 12/28/70 that (I) (we) last saw the deceased alive on 12/28/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Paul Whelton M.D. B.C.H. B.A.O. DEGREE		23B. DATE SIGNED 12/28/70	
23C. PHYSICIAN'S NAME (Type) PAUL WHELTON DEGREE		23D. ADDRESS 40 Johns Hopkins Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-30-70	
24C. NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery		24D. LOCATION (City, town, or county) (State) Howard County, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 31 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR		ADDRESS 124 Chester Ave.	



## FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12699	
70 12699					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>Octavia V. Nash</i>			2. DATE AND HOUR OF DEATH <i>12/30/70 11:50 AM</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>The Johns Hopkins Hospital</i>			A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <i>4434 St. Georges Ave</i>			2710		
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>4/19/15</i>	9. AGE (In years last birthday) <i>55</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stock girl</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY <i>Shoe store</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <i>John T. Nash, Sr.</i>		
14. MOTHER'S MAIDEN NAME <i>LESSIE</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		
16. SOCIAL SECURITY NO.			17. INFORMANT <i>John T. Nash, Jr.</i>		
ADDRESS <i>3126 NORMAN AVE</i>			18. CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>199.1 I</i>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Hemorrhage</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <i>Malignant tumor</i> DUE TO, OR AS A CONSEQUENCE OF: <i>5/18 Attempted resection</i>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>&gt; 1 yr.</i>			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION <i>12/30/70</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Malignant tumor</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/27/70</i> 19 to <i>12/30/70</i> 19, that (I) (we) last saw the deceased alive on <i>12/30/70</i> 19, and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>D.R. Neilson, Jr. - MD</i>			23B. DATE SIGNED <i>12/30/70</i>		23C. PHYSICIAN'S NAME (Type) <i>Duncan R. Neilson, Jr. M.D.</i>
23D. ADDRESS <i>Johns Hopkins Hospital</i>			24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		
24B. DATE <i>1/4/71</i>			24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Memorial Park</i>		
24D. LOCATION (City, town, or county) (State) <i>BALTO. Co. (Arbutus) Md.</i>			25A. DATE REC'D BY HEALTH DEPT. <i>DEC 31 1970</i>		
25B. NAME OF REGISTRAR <i>Robert E. Taylor, R.D.</i>			25C. FUNERAL DIRECTOR <i>1735 HARFORD AVE</i>		



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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 12700</b>	
70 12700				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Marie W. Greif</b>		2. DATE AND HOUR OF DEATH <b>12-26-70 1 9<sup>50</sup> P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY		C. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Keswick - Home for Incurables</b> 700 W. 40th Street Ba Ho., Md. 21241		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>522 N. Highland Avenue 2610</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-16-81</b>	9. AGE (in years last birthday) <b>89</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home Maker</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
13. FATHER'S NAME <b>Carl Picker</b>		14. MOTHER'S MAIDEN NAME <b>Marie Conrad</b>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>D 213-05-9583</b>		17. INFORMANT <b>Records; Keswick</b>	
18. <b>412.3</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Anteapneumatic Heart</b> Disease & Congestive Heart Failure <b>Osteoarthritis</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-16</b> 19 <b>70</b> to <b>12-26</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>12-26</b> 19 <b>70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>E. H. Wilson Jr.</b>		23B. DATE SIGNED <b>12-27-70</b>		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS		23E. ADDRESS		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-29-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		24E. LOCATION		24F. LOCATION	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 31 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Faber, M.D.</b>		25C. FUNERAL DIRECTOR <b>John C. Miller Inc-6415 Belair Rd.-21206</b>	

000-100

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15-25

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12-16

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12-20

# FUNERAL DIRECTOR: IMPORTANT

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## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. **70 12701**

BIRTH NO. **70 12701**

1. NAME OF DECEASED  
(Type or Print)

**MABEL HAETLER**

2. DATE AND HOUR OF DEATH

**12-26-70**

**7**

**A M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

**BOLTON HILL NURSING CENTER**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

**MARYLAND**

C. CITY OR TOWN  
**BALTIMORE**

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

**2865 CHESTERFIELD**

**831**

5. SEX

**F**

6. RACE

**W**

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

**9-22-06**

9. AGE (In years  
last birthday)

**74**

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

**Practical Nurse**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Balto. Md.**

12. CITIZEN OF WHAT COUNTRY?

**U.S.A.**

13. FATHER'S NAME

**John Nace**

14. MOTHER'S MAIDEN NAME

**Elizabeth Kenzes**

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

**216-18-9162**

17. INFORMANT

**ADMISSION RECORD**

ADDRESS

18. **153.8 I**

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

**CAD clean embolism**

**months**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B) **chronic coronary artery disease**

DUE TO, OR AS A CONSEQUENCE OF:

**years**

(C) **arteriosclerosis**

**years**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

White At ☐

Nat While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from **11/20** 19**70** to **12/26** 19**70**,  
that (I) (we) last saw the deceased alive on **12/26** 19**70** and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

**AL Macht**

DEGREE

Attending  
Phys.

Med.  
Director ☒

Staff  
Phys. ☐

23B. DATE SIGNED

**12/28/70**

23C. PHYSICIAN'S  
NAME (Type)

**ALAN H. MACHT MD**

DEGREE

23D. ADDRESS

**26 Red St Baltimore, Md**

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

**Burial**

**12-29-70**

**Mt. Olivet Cemetery**

**Baltimore, Maryland**

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

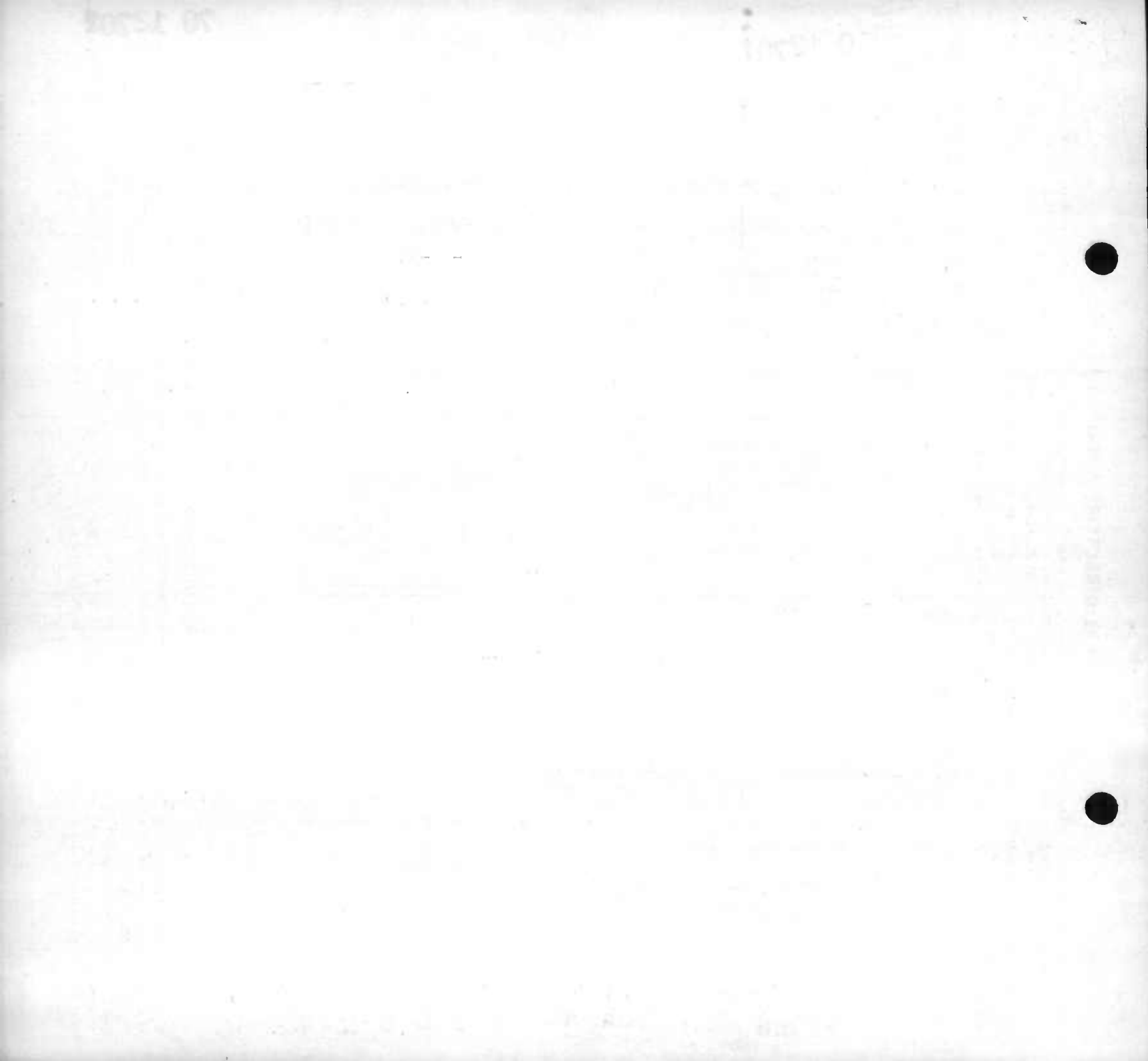
ADDRESS

**DEC 31 1970**

**Robert E. Gable, R.A.**

**2**

**John C. Miller Inc. 06415 Belair Rd.**

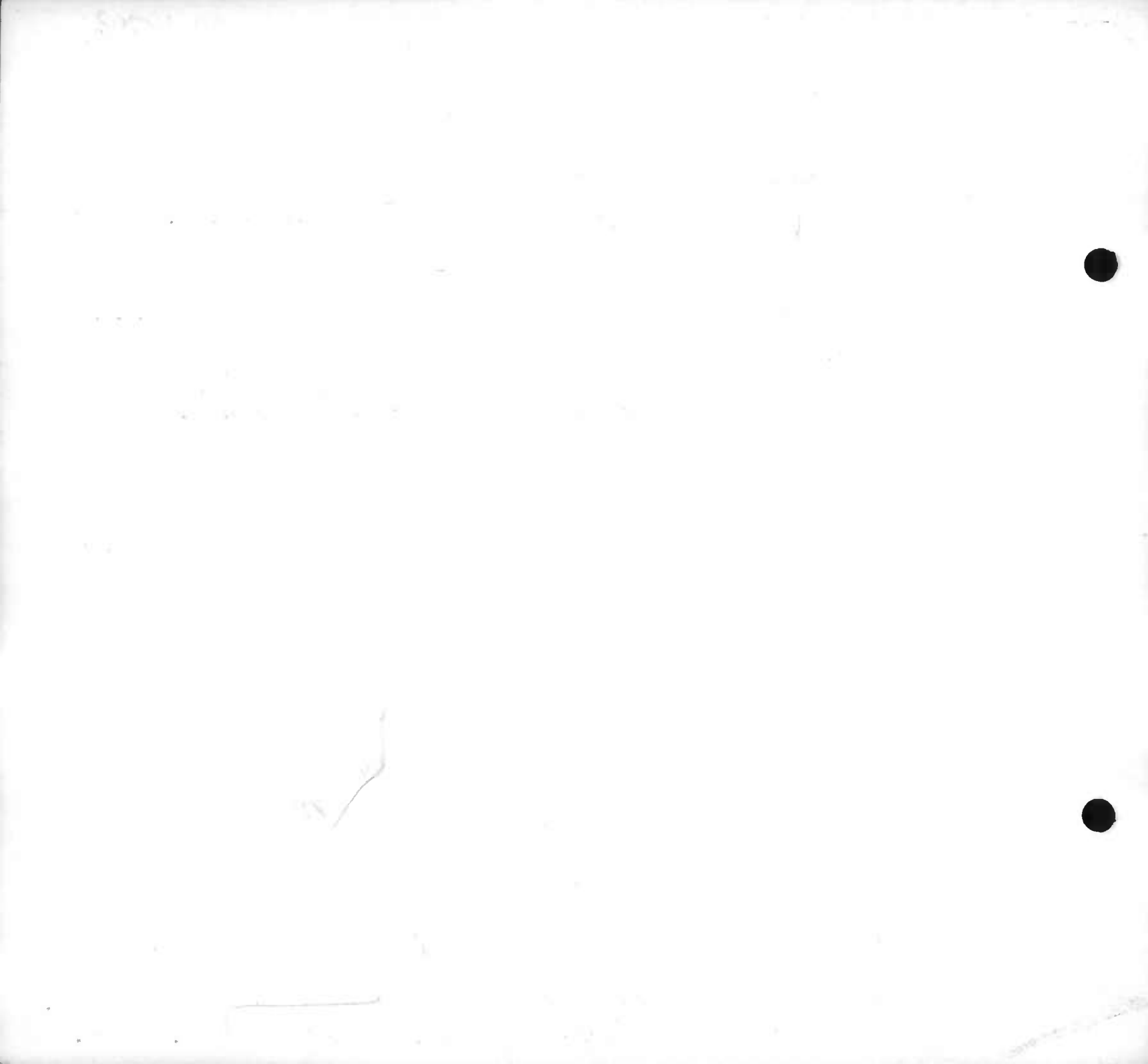


BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Sarah Krueger (Kreuger)		12/28/20 11:05 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				B. COUNTY 2302	
5. SEX Female		6. RACE White		C. CITY OR TOWN Baltimore	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-2-01		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Food Demonstrator		10B. KIND OF BUSINESS OR INDUSTRY		E. STREET AND NUMBER 1435 Patapsco St., Balto. Md. 21230 007	
13. FATHER'S NAME <del>unknown</del> John Tregoe				14. MOTHER'S MAIDEN NAME <del>unknown</del> Mary Campbell	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-26-5262A		17. INFORMANT 4940 Eastern Avenue BCH Records: Baltimore, Md. 21224	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 19 20</u> to <u>12/28/19 20</u> that (I) (we) last saw the deceased alive on <u>12/28 19 20</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jeremiah Duwel</i>				23B. DATE SIGNED 12/28/20	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. MEDICAL DIRECTOR	
Jeremiah Duwel MD		BCH		McCully Funeral Home 130 E. Fort Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12/31/20		Cedar Hill Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 31 1970		Robert E. Fisher, M.D.		McCully Funeral Home 130 E. Fort Ave.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H2201

70 12703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

70 12703

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Hughes, Florence E*

2. DATE AND HOUR OF DEATH

*12/27/70 957 P.M.*

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

*South Baltimore General Hospital*

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  
A. STATE B. COUNTY

*Baltimore Maryland*

C. CITY OR TOWN

*Baltimore*

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

*2226 Gedley St.*

*2533*

5. SEX

*F*

6. RACE

*W*

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

*March 3, 1903*

9. AGE (In years last birthday)

*67*

10. Under 1 Yr. 11. Under 24 Hrs. 12. Under 24 Hrs. 13. Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Housewife*

10B. KIND OF BUSINESS OR INDUSTRY

*At Home*

11. BIRTHPLACE (State or foreign country)

*Pennsylvania*

12. CITIZEN OF WHAT COUNTRY?

*U S A*

13. FATHER'S NAME

*Robert Lloyd*

14. MOTHER'S MAIDEN NAME

*Unknown Unknown*

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

*No*

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Mr. Michael R. Hughes 2210 Annapolis Rd.*

18. *250.9 I*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

*Metabolic Acidosis*

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

*One day*

(B) DUE TO, OR AS A CONSEQUENCE OF:

*Chronic Renal Failure*

*3 years*

(C) DUE TO, OR AS A CONSEQUENCE OF:

*Diabetes mellitus*

*Many years*

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (naffly medical examined)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from *11-23-1970* to *12-27-1970* that (I) (we) last saw the deceased alive on *11-27-1970* and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

*C. Carter M.D.*

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

*12-27-70*

23C. PHYSICIAN'S NAME (Type)

*Colvin C. Carter M.D.*

23D. ADDRESS

*3001 S. Hanover St.*

24A. BURIAL CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*12 31 70*

24C. NAME OF CEMETERY or CREMATORY

*Glen Haven*

24D. LOCATION

(City, town, or county)

(State)

*Glen Burnie, A. A. Co. Md.*

25A. DATE REC'D BY HEALTH DEPT.

*DEC 31 1970*

25B. NAME OF REGISTRAR

*Robert E. Farley M.D.*

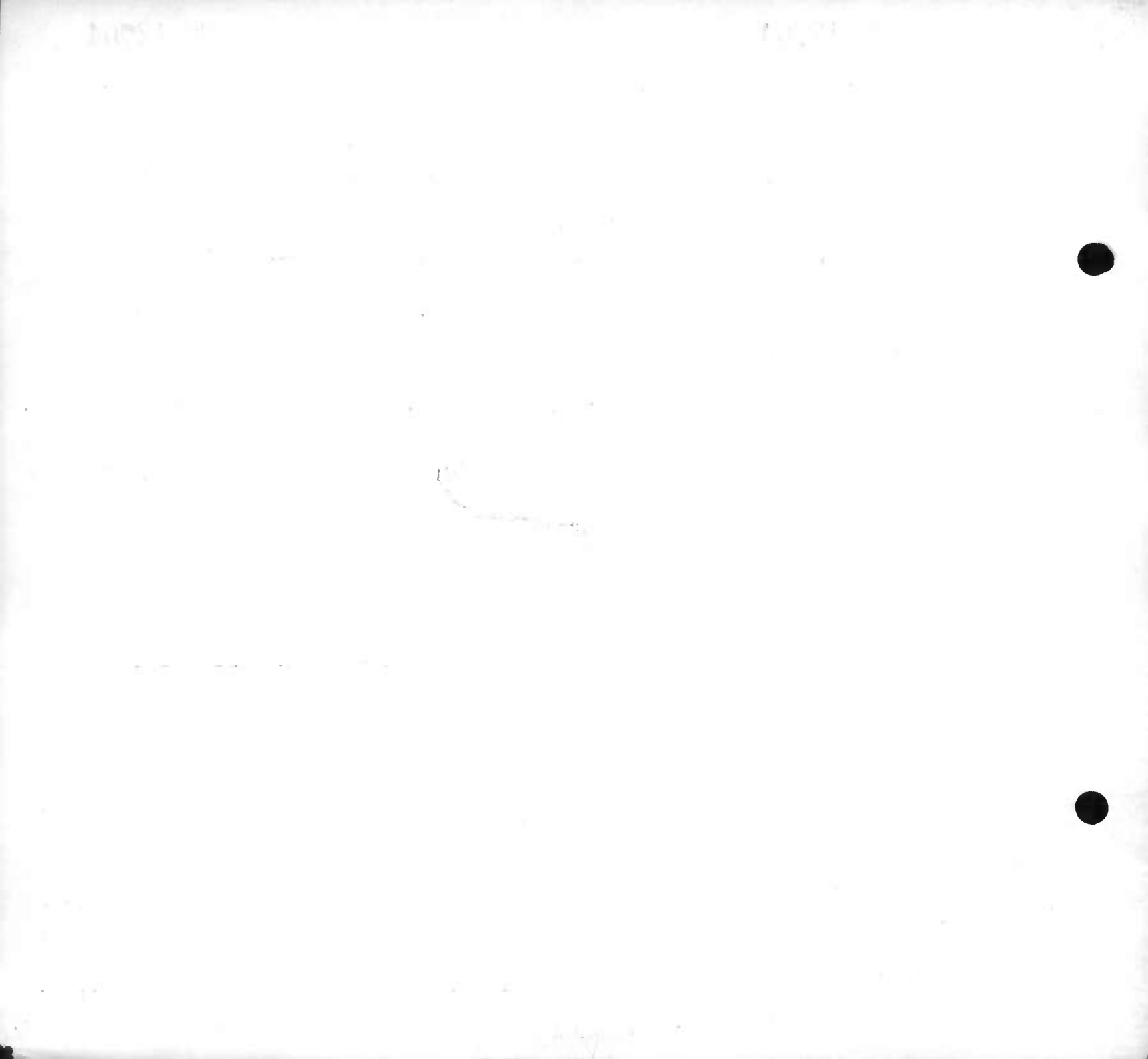
25C. FUNERAL DIRECTOR

*Mc Gully 130 E. Fort Ave*



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

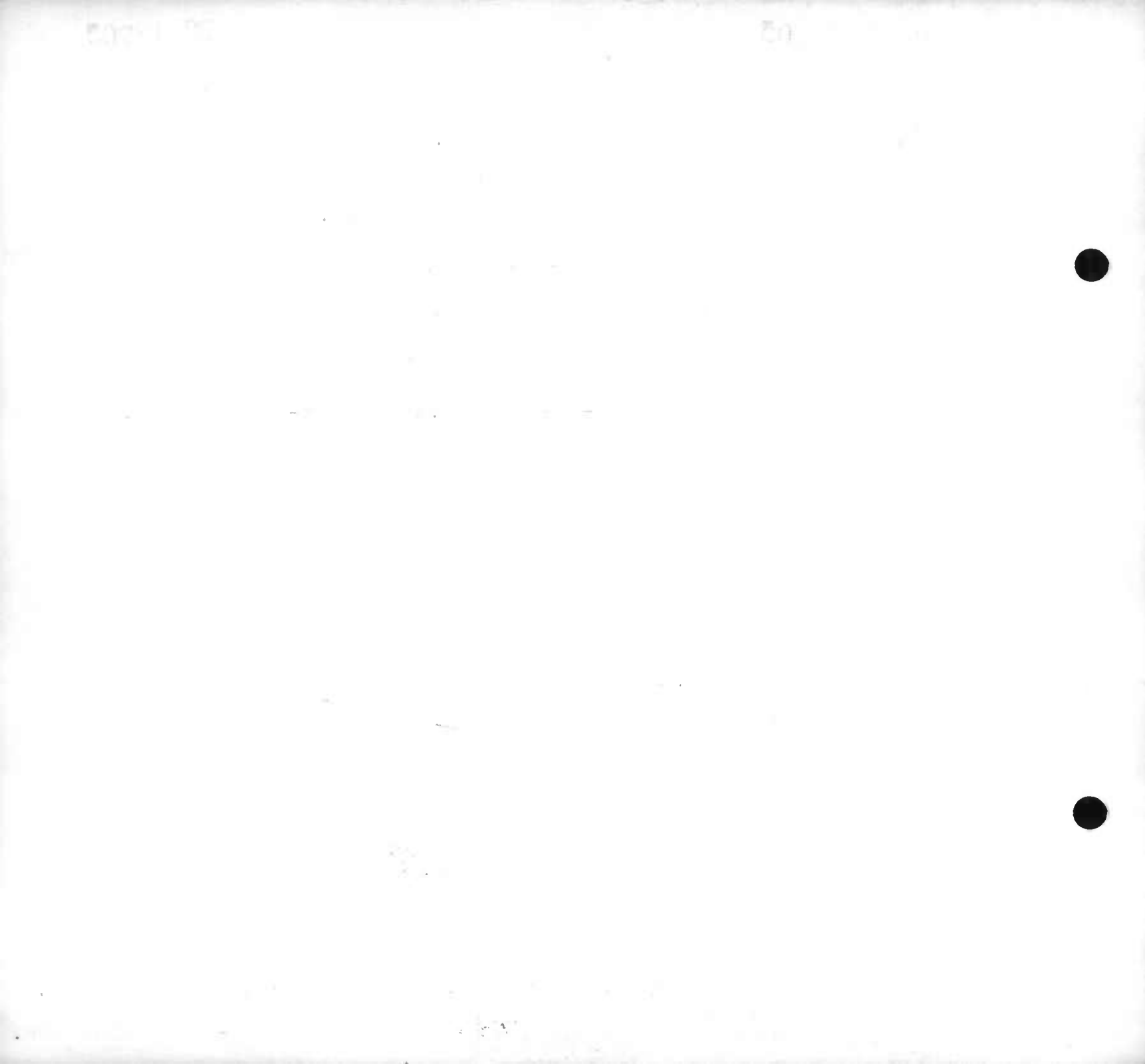
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 12704</b>	
70 12704 CERTIFICATE OF DEATH					
BIRTH NO. <b>70 12704</b>		1. NAME OF DECEASED (Type or Print) <b>CLARENCE GIDDINGS</b>			
2. DATE AND HOUR OF DEATH <b>DECEMBER 28, 1970 7:35 A.M.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTIMORE</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>10-13-03</b>		9. AGE (In years last birthday) <b>67</b>		10. UNDER 1 Yr. Months: Days: Hours: Min.	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Harry Giddings</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-07-6440A</b>		17. INFORMANT <b>Mrs. Virginia Giddings-3420 Ash St.</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction 11 hours</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic Heart Disease</b>		(B) _____ (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>DECEMBER 27, 1970</b> to <b>DECEMBER 28, 1970</b> that (1) (we) last saw the deceased alive on <b>DECEMBER 28, 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Benjamin R. Chipman, M.D.</b>		23B. DATE SIGNED <b>December 28, 1970</b>		23C. PHYSICIAN'S NAME (Type) <b>Benjamin R. Chipman, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/31/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Emmanuel Meth. Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Scaggsville, Howard Co., Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>JEC 31 1970</b>		24F. NAME OF REGISTRAR <b>Robert E. Jolley, Jr.</b>	
24G. FUNERAL DIRECTOR <b>Donovan Funeral Home-3818 Roland Ave.</b>		24H. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

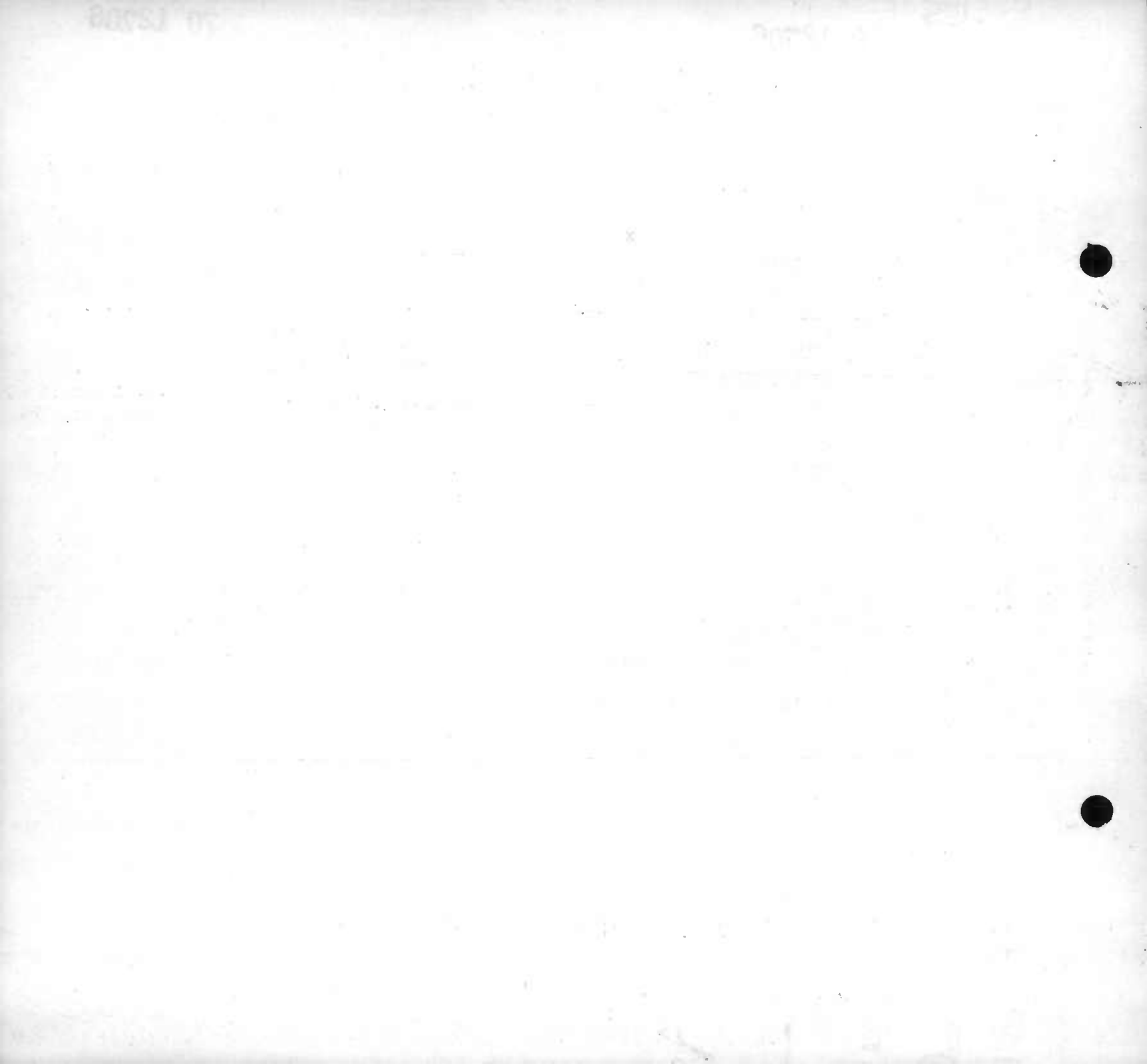
70 12705		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12705	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Thomas Wade Davis</i>		2. DATE AND HOUR OF DEATH <i>12/28/70 4:10 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE & COUNTY <i>Md.</i>		C. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>3/18/11</i>		9. AGE (in years lost birthday) <i>59</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Self-Employed</i>	
11. BIRTHPLACE (State or foreign country) <i>Delaware</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>		13. FATHER'S NAME <i>Neal Davis</i>	
14. MOTHER'S MAIDEN NAME <i>? Tyson</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-10-3133</i>	
17. INFORMANT <i>Mrs. Rose Davis-3713 Elm Ave.</i>		ADDRESS		18. <i>410.9 I</i> CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Acute myocardial</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <i>Infarction</i>		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/25/1970</i> to <i>12/28/1970</i> that (I) (we) last saw the deceased alive on <i>12/28/1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>		23B. DATE SIGNED <i>12/28/70</i>		23C. PHYSICIAN'S NAME (Type) <i>X41 X41 LWTN</i>	
23D. ADDRESS <i>Mercy Hospital</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/31/70</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 31 1970</i>	
25B. NAME OF REGISTRAR <i>Robert E. Farley, R.D.</i>		25C. FUNERAL DIRECTOR <i>Donovan Funeral Home-3818 Roland Ave.</i>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 12706</b>	
BIRTH NO. <b>70 12706</b>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JOSEPH F. HORWATH</b>		2. DATE AND HOUR OF DEATH <b>12-27-70 1345 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 THE JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Cecil</b>			
		C. CITY OR TOWN <b>NORTH EAST</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <b>RD 1 BOX 257 C 5700</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-19-24</b>	9. AGE (In years last birthday) <b>46</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Mechanic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Auto Repair</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>FREDERICK HORWATH</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET Vasger</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>176-18-0452</b>		17. INFORMANT <b>Lorraine M. Horwath</b>	
				ADDRESS <b>R.D. 1 Box 257 C North East, Md.</b>	
18. <b>5710 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>GI bleed, hepatic Coma</b>  (B) <b>Alcoholism, Cirrhosis yrs</b>  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 d</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) lost saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Anthony S. Jennings MD</b> DEGREE				23B. DATE SIGNED <b>12-27</b>	
23C. PHYSICIAN'S NAME (Type) <b>ANTHONY S. JENNINGS</b> DEGREE				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/30/70</b>	24C. NAME OF CEMETERY or CREMATORY <b>St. Mary Anne's</b>		24D. LOCATION (City, town, or county) (State) <b>North East Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 31 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Grant Funeral Home</b> ADDRESS <b>North East Md.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be completed by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12707

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 12707

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ELSIE Rohrbach

2. DATE AND HOUR OF DEATH

22 Dec 1970

4:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospital  
4940 Eastern Avenue Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

6124 Shipview Way 21224

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

Oct 27 1939

9. AGE (in years last birthday)

31

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Feester

14. MOTHER'S MAIDEN NAME

Dorota Feester ENORA ZOETMAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

BCH: Records

4940 Eastern Avenue  
Baltimore, Md. 21224

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

Vesico Vaginal Fistula

(B) RADIATION Necrosis of Bladder  
DUE TO, OR AS A CONSEQUENCE OF:

(C) Cancer of the Cervix

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Dec 1970

Dec 1970

July 1969

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

Dec 21, 1970

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Vesico-vaginal Fistula

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

No

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/15/1970 to 12/22/1970 that (I) (we) last saw the deceased alive on 12/22/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Gerald Sufrin MD

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

Dec 22, 1970

23C. PHYSICIAN'S NAME (Type)

Gerald Sufrin, MD

23D. ADDRESS

Baltimore City Hospitals  
4940 Eastern Ave. Balto., Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-24-70

24C. NAME OF CEMETERY OR CREMATORY

Mt. Olivet Cemetery

24D. LOCATION (City, town, or county) (State)

Hanover York Co Pa.

25A. DATE REC'D BY HEALTH DEPT.

DEC 31 1970

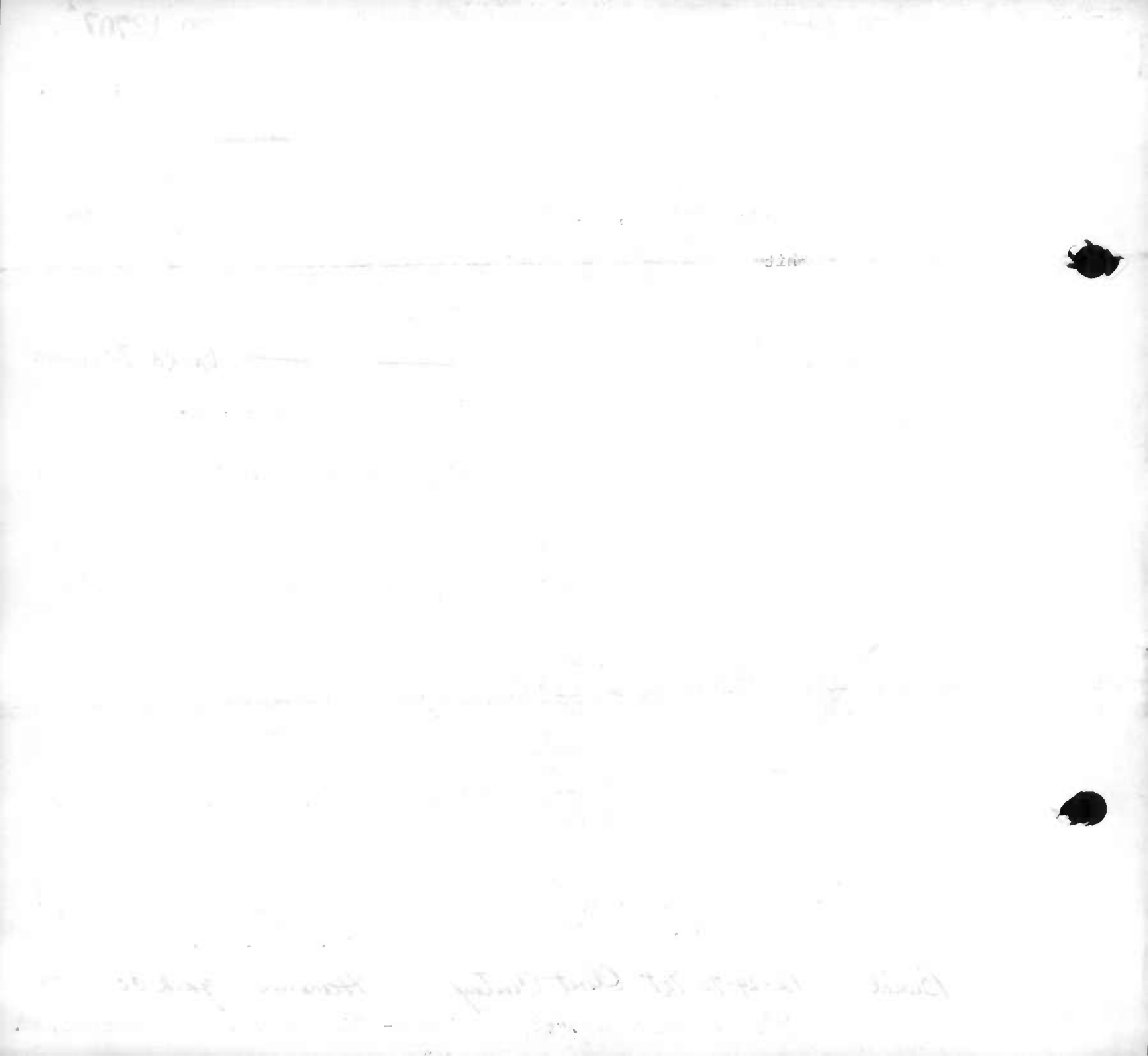
25B. NAME OF REGISTRAR

Robert E. Farber, MD

25C. FUNERAL DIRECTOR

Tipton - Eline Funeral Home

Hampstead, Md.



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W 426

1/21/81 Film#G-551-mdf BALTIMORE CITY HEALTH DEPARTMENT  
70 12708 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 12708

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> 12/29/70		3. DATE OF DEATH Month Day Year Hour	
PHYLLIS LEE (Phyllis Walker Lee)		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		6. SEX	
MERCY HOSPITAL		7. RACE Female Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH 4/10/48	
10. AGE (In years last birthday) 22		11. BIRTHPLACE (State or foreign country) Balto Md		12. CITIZEN OF U S A		13. FATHER'S NAME Cornelius Walker	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		15. MOTHER'S MAIDEN NAME Mattie L Glover HARDY		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Rev Phyllis Hardy, same		19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Gunshot wound of Abdomen (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ?		22C. WHERE DID INJURY OCCUR? 119 S. Exeter Street		22D. TIME (Month) (Day) (Year) (Hour) 12-29-70 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Gunshot wound of abdomen		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. DATE 12/1/70		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A A County Md		25A. DATE REC'D BY HEALTH DEPT. DEC 31 1970		25B. NAME OF REGISTRAR Robert E. Pober, M.D.		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North	

50 15308

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B260

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 70 12709

BIRTH NO. 70 12709

1. NAME OF DECEASED  
(Type or Print) LAURA BAKER

2. DATE AND HOUR OF DEATH  
12/26/70 1:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

LUTHERAN HOSPITAL OF MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND B. COUNTY 21216

C. CITY OR TOWN BALTIMORE

D. INSIDE CITY LIMITS? YES ☒ NO ☐

E. STREET AND NUMBER 3406 BATEMAN AVENUE 1538

5. SEX F

6. RACE C

7. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9. AGE (in years last birthday) 78

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 2222

16. SOCIAL SECURITY NO. 2222

17. INFORMANT ADDRESS CHART, 2222

18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

CEREBRO VASCULAR ACCIDENT WITH PULMONARY EDEMA

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ATRIAL FLUTTER.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

ASCVD.

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

NO INJURY

22. I certify that (I) (this hospital) attended the deceased from 19 to 12/26/1970 that (I) (we) last saw the deceased alive on 12/26/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

R. George Thomas MD

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED

12/26/70

23C. PHYSICIAN'S NAME (Type)

R. GEORGE THOMAS MD

23D. ADDRESS

LUTHERAN HOSPITAL OF MD.

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

12/30/70

24C. NAME OF CEMETERY OR CREMATORY

M Calvary Cemetery

24D. LOCATION

(City, town, or county)

A A County Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 31 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, R.D.

25C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 12710

BIRTH NO. 70 12710

1. NAME OF DECEASED  
(Type or Print)

TYMES JOSEPH RICHARD

2. DATE AND HOUR OF DEATH

12-27-70 12-15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNIVERSITY HOSPITAL 4-13  
BALTIMORE 21201

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE B. COUNTY  
SPRING FIELD State Hospital

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

E. STREET AND NUMBER

13-01

5. SEX

Male

6. RACE

N.

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

5-30-23

9. AGE (In years lost birthday)

45

10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY

U S A

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

231-14-1846

17. INFORMANT

Chart

ADDRESS

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CARCINOMA - LUNG

(B)

DUE TO, OR AS A CONSEQUENCE OF:

CARCINOMA - LUNG

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-26-1970 to 12-27-1970 that (I) (we) last saw the deceased alive on 12-27-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Gopalakrishnan

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

12-27-70

23C. PHYSICIAN'S NAME (Type)

DR. GOPALA KRISHNAN

DEGREE

23D. ADDRESS

UNIVERSITY HOSPITAL 21201

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/31/70

24C. NAME OF CEMETERY OR CREMATORY

MT Calvary Cemetery

24D. LOCATION

(City, town, or county)

A A County

(State)

ADDRESS

25A. DATE REC'D BY HEALTH DEPT.

DEC 31 1970

25B. NAME OF REGISTRAR

Robert E. Fahey, M.D.

25C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

address - 2523 Brookfield Ave  
Lfr → Halstead Funeral Home

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>70 12711</b>	
BIRTH NO. <b>70 12711</b>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>WARDELL EARLY</b>		2. DATE AND HOUR OF DEATH <b>12/30/70 3:45 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GENERAL HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <b>MD.</b> B. COUNTY  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1716 MC Cullough St 1402</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>8/29/11</b>	9. AGE (In years last birthday) <b>59</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Hartford, Conn.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Marcel Early</b>			
14. MOTHER'S MAIDEN NAME <b>Idora Dudley</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>241 24 3347</b>	
17. INFORMANT <b>Garie Early</b>		ADDRESS			
18. <b>189.0 I</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <b>Hemopneumothorax</b> DUE TO <b>(R) RENAL CELL CARCINOMA</b> (B) _____ DUE TO (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Chronic renal failure</b>			
19A. DATE OF OPERATION <b>12/29/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Renal artery thrombosis</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. INJURY OCCURRED		21E. HOW DID INJURY OCCUR?			
21F. WHILE AT Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <b>12/16/70</b> to <b>12/30/70</b> 19_____, that (I) (we) last saw the deceased alive on <b>12/30/70</b> 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>V. R. Felipa</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/30/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Victor R. Felipa</b>		23D. ADDRESS <b>Maryland General Hospital</b>			
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/31</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Md</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 31 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR <b>William L. Morgan</b>	
ADDRESS		<b>2302 W. North Ave</b>			

1551 00

1551 00



70 12712

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 12712

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>EDITH YINGST</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 12 16 1970 2:55 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3803 Kimble Ave.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 16 1970 2:55 p.m.	
6. SEX female		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 12/23/10		10. AGE (In years lost birth day) 60	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? ?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		14B. KIND OF BUSINESS OR INDUSTRY market	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. ?	
18. INFORMANT TAT WASHBURN		ADDRESS WOOLMAN APT	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fatty liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Isidore Mihalakis</i> M.D. EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. DATE SIGNED 12-17-70			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 12/30/70	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) Q.A. County, Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 31 1970		25B. NAME OF REGISTRAR Robert E. [illegible]	
25C. FUNERAL DIRECTOR Joseph [illegible]		ADDRESS 1304 [illegible]	

NO 15218

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF

Name of Deceased	
Age	
Sex	
Race	
Date of Death	
Place of Death	
Cause of Death	
Manner of Death	
Signature of Medical Examiner	
Signature of Coroner	
Signature of Registrar	
Signature of Witness	
Signature of Physician	
Signature of Nurse	
Signature of Undertaker	
Signature of Burial Place	
Signature of Cemetery	
Signature of Funeral Home	
Signature of Other	

140 34 26  
PUMPHREY, ALFRED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12713		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12713	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ALFRED L. PUMPHREY		12-29-70 9:45 P	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY B C. CITY OR TOWN BALTIMORE E. STREET AND NUMBER 1711 WAVERLY WAY APT B. 2758		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 14-20-04	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Balto. City Market Master		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wash. D.C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME REGINALD PUMPHREY		14. MOTHER'S MAIDEN NAME ELLEN BARLEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-07-7331		17. INFORMANT Gertrude Pumphrey same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF: (B) 2nd Bilat. gram neg. pneumonia DUE TO, OR AS A CONSEQUENCE OF: (C) Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF: Bronchopneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 minutes 2 weeks 2 weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION 11/21/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer LUL Lung	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 21 1970 to Dec. 29 1970, that (I) (we) last saw the deceased alive on Dec. 29 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ellis L. Jones		23B. DATE SIGNED 12/29/70			
23C. PHYSICIAN'S NAME (Type) ELLIS L. JONES		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/2/71		24C. NAME OF CEMETERY or CREMATORY Parkwood	
24D. LOCATION Balto. Md.		24E. DATE REC'D BY HEALTH DEPT. DEC 31 1970		24F. NAME OF REGISTRAR Robert E. Fisher, M.D.	
24G. DATE REC'D BY HEALTH DEPT. DEC 31 1970		24H. NAME OF REGISTRAR Robert E. Fisher, M.D.		24I. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.	



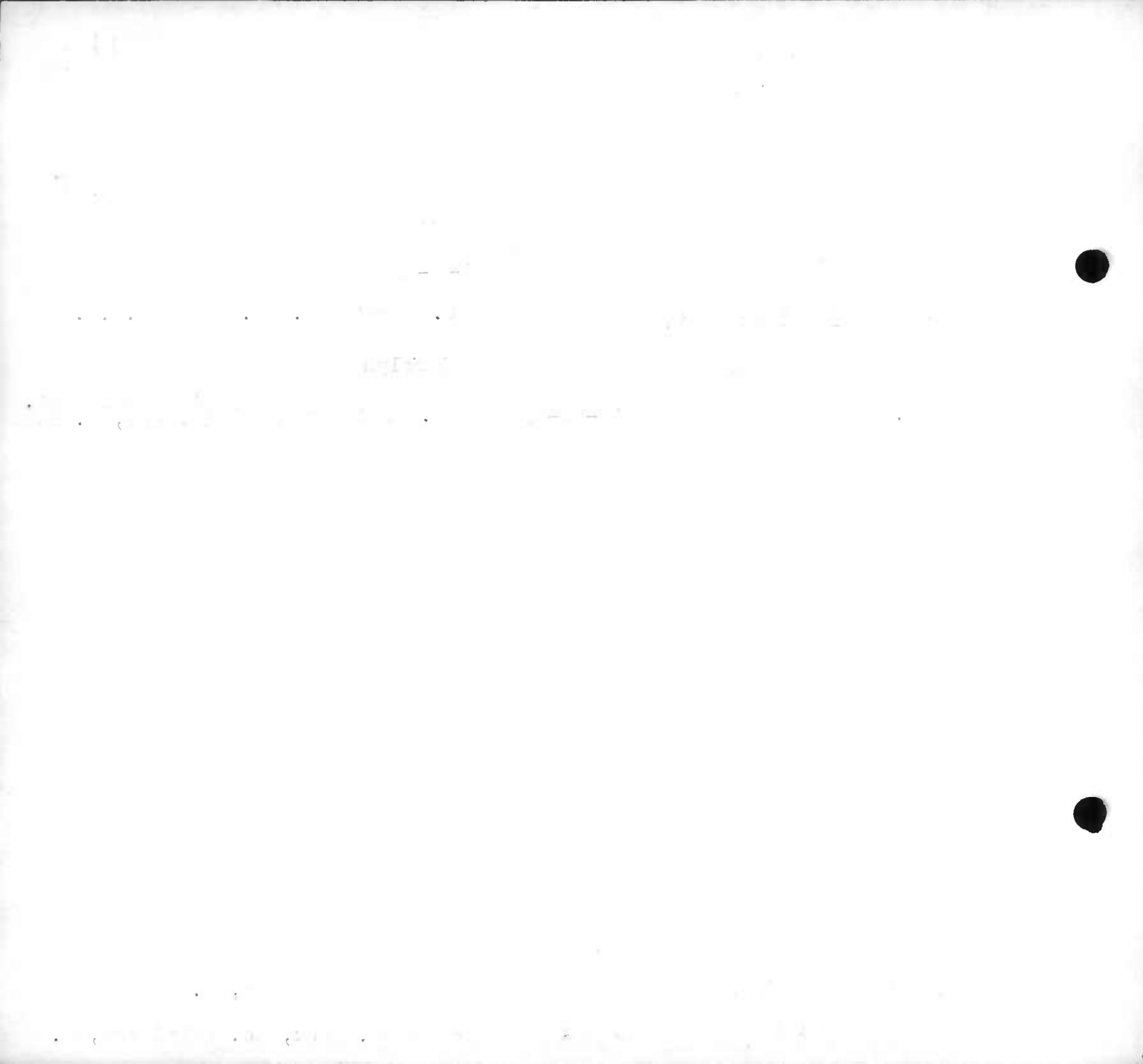
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 70 12714

BIRTH NO. 70 12714

1. NAME OF DECEASED (Type or Print) <b>Charles Gilbert McKay</b>				2. DATE AND HOUR OF DEATH <b>12/28/70 1 9:55 P M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MERCY HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1130 Gorsuch Ave 905</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-22-04</b>		9. AGE (In years last birthday) <b>66</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steam Ship Clerk (Ret)</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>St. Mary's Co. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Joseph McKay</b>			
14. MOTHER'S MAIDEN NAME <b>Carblyn Brady</b>				15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) <b>Yes.</b>			
16. SOCIAL SECURITY NO. <b>212-01-4592</b>				17. INFORMANT <b>Mrs. Susie Bowles Baltimore, Md. 21206</b>			
18. CAUSE OF DEATH <b>150X1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <b>2</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>YES.</b> 20A. AUTOPSY? (Yes or No) <b>YES.</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12/24/70</b> to <b>12/28/70</b> and that (I) (we) lost saw the deceased alive on <b>12/28/70</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>K. L. W. Z. N.</b>				23B. DATE SIGNED <b>12/29/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>KYI KYI LWN</b>				23D. ADDRESS <b>Mercy Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/2/71</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 31 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, Jr.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.</b>		ADDRESS <b>Baltimore, Md.</b>	



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70 12715

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12715

BIRTH NO.		1. NAME OF DECEASED (Type or Print) CALVIN WESLEY ZELLERS Jr.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year December 29, 1970		Hour 6:15 P.M.	
6. SEX Male		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 1/11/1920		10. AGE (In years last birthday) 50		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF USA		13. FATHER'S NAME Calvin Wesley Zellers Sr		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Highway Engineers State Roads	
15. MOTHER'S MAIDEN NAME Bertha Mae Fraley		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes WW2		17. SOCIAL SECURITY NO. 219-05-0813	
18. INFORMANT Sarah Jane Zellers same		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gunshot wound of head (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes (Head-Only)	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1712 Hillenwood Rd.	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12-29-70 5:55 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Self-inflicted gunshot wound of head	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> (Head-Only) Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/30/70					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/2/71		24C. NAME of CEMETERY or CREMATORY Woodlawn Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 31 1970			
25B. NAME OF REGISTRAR Robert E. Talbot, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12716		BALTIMORE CITY HEALTH DEPARTMENT		70 12716	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
LOWMAN, HENRY L		12-28-1970		11:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
UNION MEMORIAL HOSPITAL		MARYLAND			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		5909 LAKEHURST WAY 2758			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. Under 1 Yr. Months Days
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	03-06-'04	66	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Engineering		Maguolo & Quick		VIRGINIA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
ROBERT W. LOWMAN		WILMA Preston Huff		USA AMERICAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		262-01-6310		Mrs Virginia G Lowman	
				ADDRESS Same	
				ADMISSION HISTORY SHEET UNION MEM. HOSP.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Carcinoma of prostate	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Prostate Adenitis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
12-21-70	Metastatic Carcinoma	YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?	(If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from 12-20-1970 to 12-28-1970 that (I) (we) lost saw the deceased alive on 12-28-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Rau		12-28-1970			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
DR R. RAU		UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION	(City, town, or county) (State)	
Burial	12-31-70	Westview Cem.	New Castle Craig	Va.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS		
DEC 31 1970	Robert E. Farber	Leonard J Ruuk Inc.	Balto. Md. 21214		

General and Special

Notes and Remarks

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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70 12717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 70 12717

BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Clayton L. Burns		Dec. 30, 1970 1 6 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mercy Hospital		A. STATE Md. B. COUNTY	
5. SEX M		C. CITY OR TOWN Baltimore	
6. RACE W		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 615 E. Baltimore St. 461	
8. DATE OF BIRTH 9-19-06		9. AGE (in years last birthday) 64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10B. KIND OF BUSINESS OR INDUSTRY Utilities	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Burns		14. MOTHER'S MAIDEN NAME Olive Kline	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) WWII		16. SOCIAL SECURITY NO.	
17. INFORMANT Gary H. Conrath		ADDRESS H. Lewisburg, Pa.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  Carcinoma of Colon With Metastasis	
19A. DATE OF OPERATION 12-30-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-21-70 to 12-30-70 that (I) (we) last saw the deceased alive on 12-30-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Boo Kean Kim		23B. DATE SIGNED 12/30/70	
23C. PHYSICIAN'S NAME (Type) Boo Kean Kim		23D. ADDRESS Mercy Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Rem. Burial		24B. DATE 12-31-70	
24C. NAME OF CEMETERY OR CREMATORY Winfield		24D. LOCATION Winfield, Pa.	
25A. DATE REC'D BY HEALTH DEPT. DEC 31 1970		25B. NAME OF REGISTRAR Robert E. Faber	
25C. FUNERAL DIRECTOR H.W. Jenkins Sons Co.		ADDRESS 4905 York Rd. Baltimore, Md. 21212	

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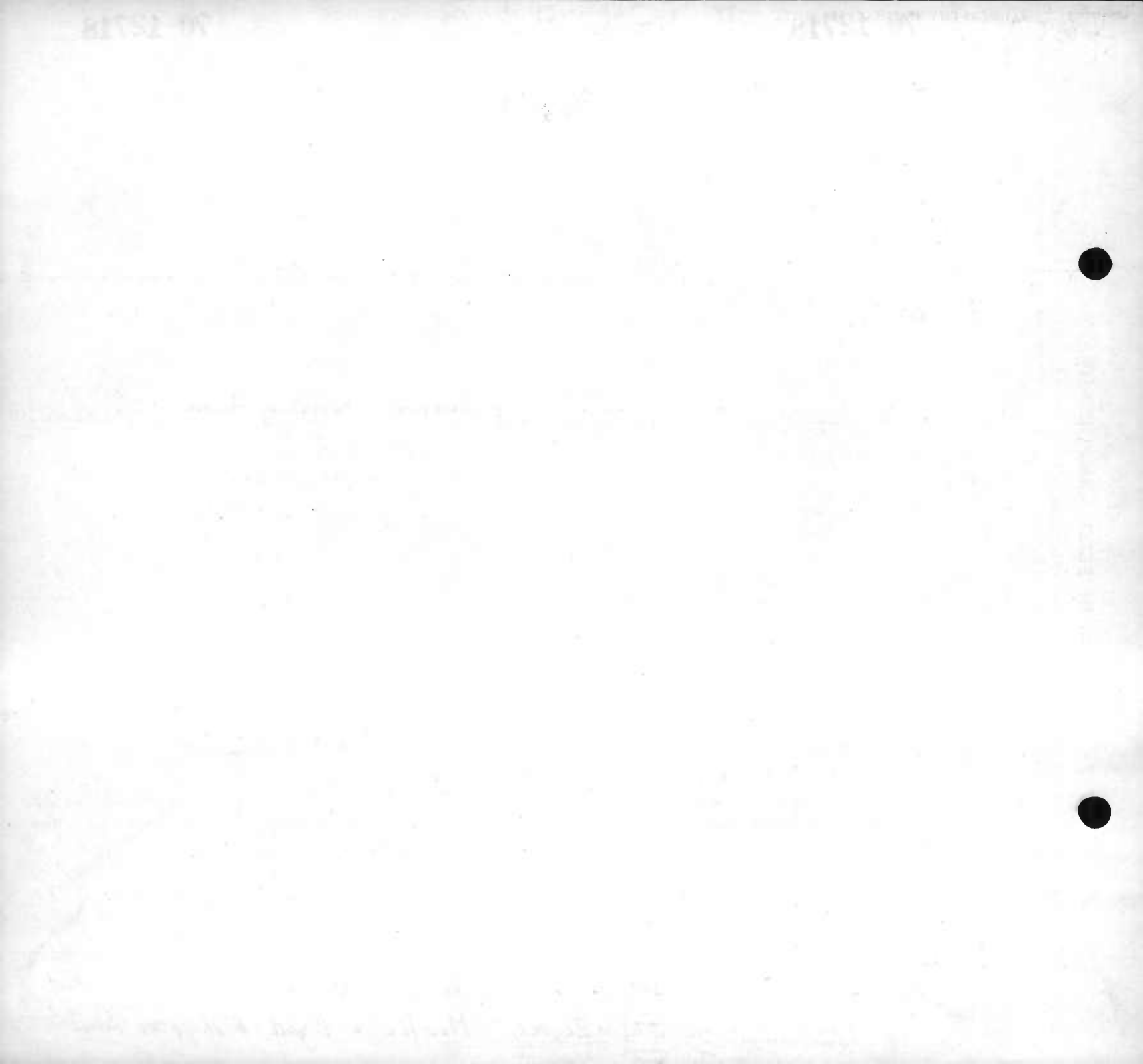
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12718		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 12718	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Gerino, Araya (Serino)</i>		2. DATE AND HOUR OF DEATH <i>12/28/70</i>   <i>8 45</i> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Garrison Nursing Home</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>male</i>		6. RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>3/24/89</i>		9. AGE (In years last birthday) <i>81</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>unknown</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes</i> <i>unknown</i>		16. SOCIAL SECURITY NO. <i>114-01-4733A</i>		17. INFORMANT <i>Garrison Nursing Home</i>	
18. <i>412.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Arteriosclerotic CV Disease &amp; Chronic Brain Syndrome</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		ADDRESS <i>2803 Garrison Blvd</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>146</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>12/28/70</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <i>this hospital</i> attended the deceased from <i>1965</i> to <i>12/28</i> 19 <i>70</i> , that (I) <i>we</i> last saw the deceased alive on <i>12/28</i> 19 <i>70</i> and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <i>we</i> (did) (did not) view the body after death.					
23A. SIGNATURE <i>Elijah Saunders</i>		23B. DATE SIGNED <i>12/28/70</i>		23C. PHYSICIAN'S NAME (Type) <i>LEI JAH SAUNDERS</i>	
23D. ADDRESS <i>2300 Garrison Blvd</i>		23E. DEGREE		23F. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/2/71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>St Thomas 2 Ave &amp; Balto Rd</i>	
24D. LOCATION (City, town, or county) (State) <i>MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 31 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>	
25C. FUNERAL DIRECTOR <i>Morton S. Dyeil F.H. 1761 Laurens St</i>		25D. ADDRESS		25E. ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

136501		70 12719		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12719	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print)				December 30, 1970			
VEATRICE L. BROWN							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
1631 N. Appleton Street				MARYLAND			
5. SEX Female				6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1-24-1911				9. AGE (in years last birthday) 59		10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Guilford, North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William				14. MOTHER'S MAIDEN NAME Martha			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.				16. SOCIAL SECURITY NO. 219-18-8985		17. INFORMANT Mr. Edward J. Brown	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH myocardial infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: myocardial infarction (B) DUE TO, OR AS A CONSEQUENCE OF: AS CVD. (C) Diabetic Mellitus.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 Mos. 7, 5, 1 yr.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/30 to 12/30 1970		that (I) last saw the deceased alive on 12/30 1970		and that (in my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.			
23A. SIGNATURE Raymond H. Caplan M.D.				23B. DATE SIGNED 12/31/70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS 1010 St. Paul St. 21202			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1-4-71		Carver Mem. Park		Laurel, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 31 1970		Robert E. Fisher, M.D.		MORTON & DYETT F.H.		1701 Laurens Street	

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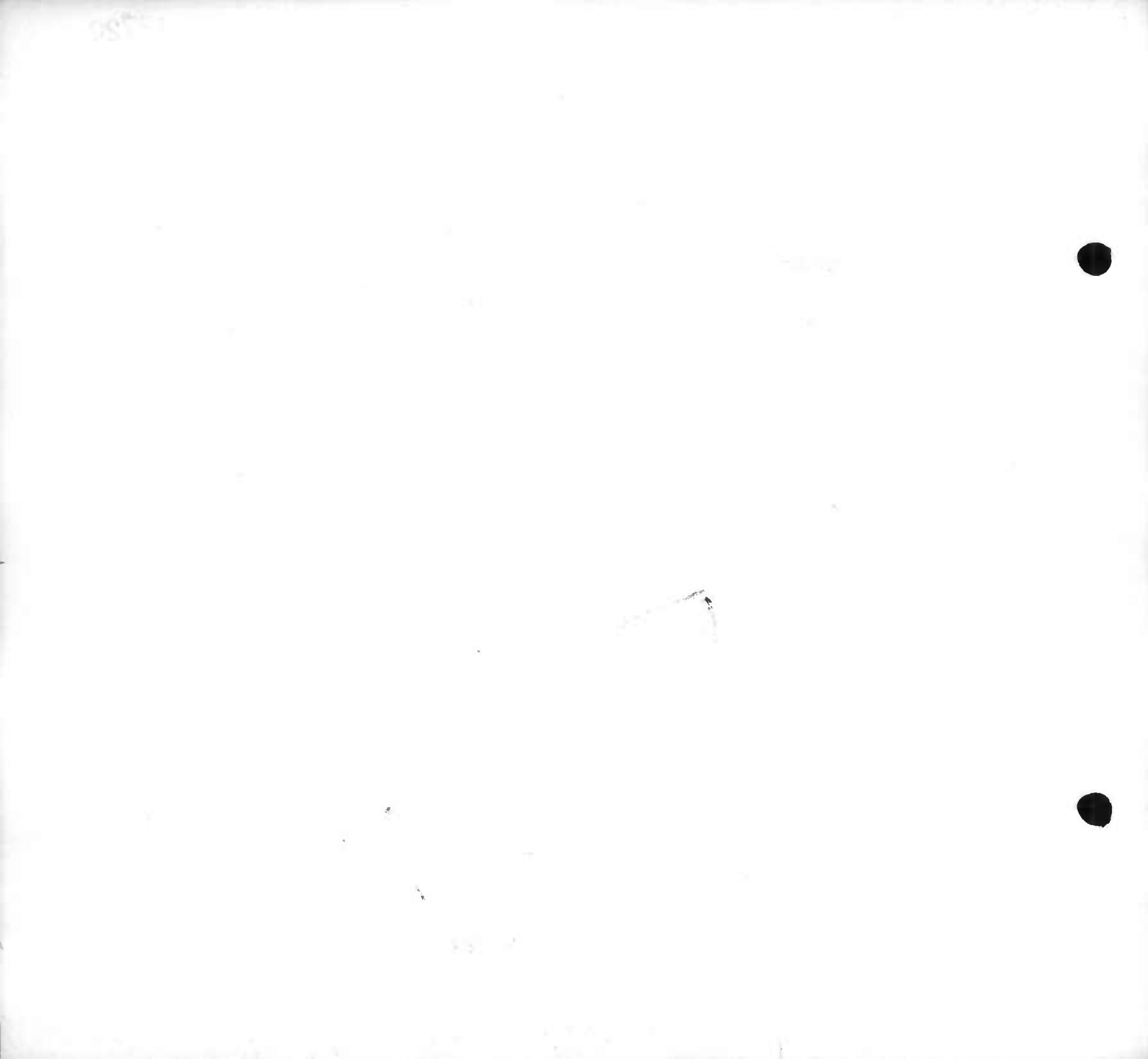
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12720		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 12720	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Brook C. Merchant</u>		2. DATE AND HOUR OF DEATH <u>12/29/70</u> <u>6:45 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN <u>Balto.</u> E. STREET AND NUMBER <u>3739 Nortonia Rd.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-9-19</u>	9. AGE (In years last birthday) <u>31</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Bala, Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William Merchant</u>		14. MOTHER'S MAIDEN NAME <u>Delilah Merchant</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>	
16. SOCIAL SECURITY NO. <u>223-24-8497</u>		17. INFORMANT <u>Mrs. Tisha Merchant</u>		ADDRESS <u>3739 Nortonia Rd.</u>	
18. <u>3739</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>PERICARDIOMYOPATHY</u> <u>PERICARDITIS + MYOCARDITIS</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>PERICARDIOMYOPATHY</u> DUE TO, OR AS A CONSEQUENCE OF: <u>PERICARDITIS + MYOCARDITIS</u> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>12/22/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/22/70</u> to <u>12/29/70</u> that (I) (we) last saw the deceased alive on <u>12/29/70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>S. Basu</u>		23B. DATE SIGNED <u>12/29/70</u>		23C. PHYSICIAN'S NAME (Type) <u>S. BASU</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>1/4/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Family Plot</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto, Virginia</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 31 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley R.D.</u>	
25C. FUNERAL DIRECTOR <u>Morton D. Dyett F.H.</u>		25D. ADDRESS <u>1701 Laurens St.</u>			



70 12721

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 12721

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>RONALD WELLS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 29, 1970 5:25 P.</b> M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
9. DATE OF BIRTH <b>9-5-1959</b>		10. AGE (In years lost birthday) <b>11</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Sorden</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>	
15. MOTHER'S MAIDEN NAME <b>Kathryn Wells</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>	
17. SOCIAL SECURITY NO. <b>-0-</b>		18. INFORMANT <b>M's Kathryn Wells</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>E929X</b>		CAUSE OF DEATH <b>Multiple Traumatic Injuries</b>	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
22A. DATE OF OPERATION		22B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22C. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22E. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>12-29-70 P.M.</b>		22F. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? <b>4300 Block Wakefield Avenue</b>	
22G. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22H. HOW DID INJURY OCCUR? <b>Subject found on street</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-5-71</b>	
24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 31 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, R.D.</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens Street</b>	

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70 12722

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 12722

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) HELEN M. HOUSTON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year December 29, 1970 Hour Minute 1:50 P.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 9-2-1936		10. AGE (in years last birthday) 34	
11. BIRTHPLACE (State or foreign country) Decal, Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Lillian Neely	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		17. SOCIAL SECURITY NO.	
18. INFORMANT Mr. Elmer Houston		ADDRESS 3039 Southland Avenue	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fatty Metamorphosis of Liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type): Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 12/30/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-5-71	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 31 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens Street	

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70 12723

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 12723

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>(LILLY) LILLY STRUELL (Lillie Spruell)</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 30, 1970 4:30 A.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>11-22-1937</b>		10. AGE (In years last birthday) <b>33</b>	
11. BIRTHPLACE (State or foreign country) <b>Newport News, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		17. SOCIAL SECURITY NO. <b>226-60-5130</b>	
18. INFORMANT <b>Mr. Franklin Spruell</b>		ADDRESS <b>2402 Roslyn Avenue</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  <b>Subdural Hematoma</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)  <b>Fatty Metamorphosis of Liver</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
22D. TIME OF INJURY (APPROX.) <b>Unk.</b>		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? <b>2402 Roslyn Avenue</b>		22F. HOW DID INJURY OCCUR? <b>Subject fell</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED <b>12/30/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-3-1971</b>	
24C. NAME OF CEMETERY or CREMATORY <b>St. Thomas Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 31 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Jaber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>MORTON B. DYETT F.H.</b>		ADDRESS <b>1701 Laurens Street</b>	

IN 12323

NO 12323

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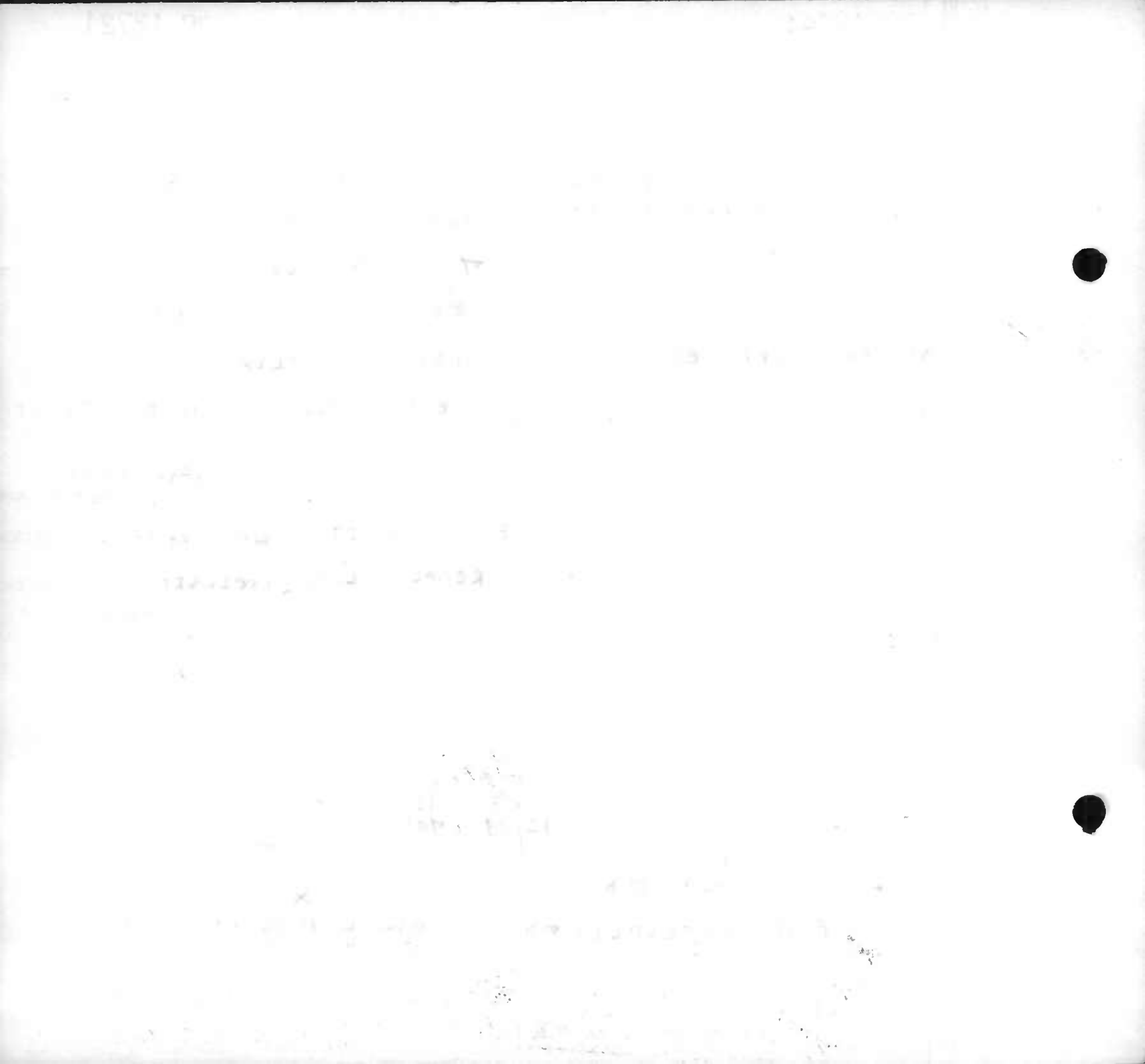
11-1-11

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

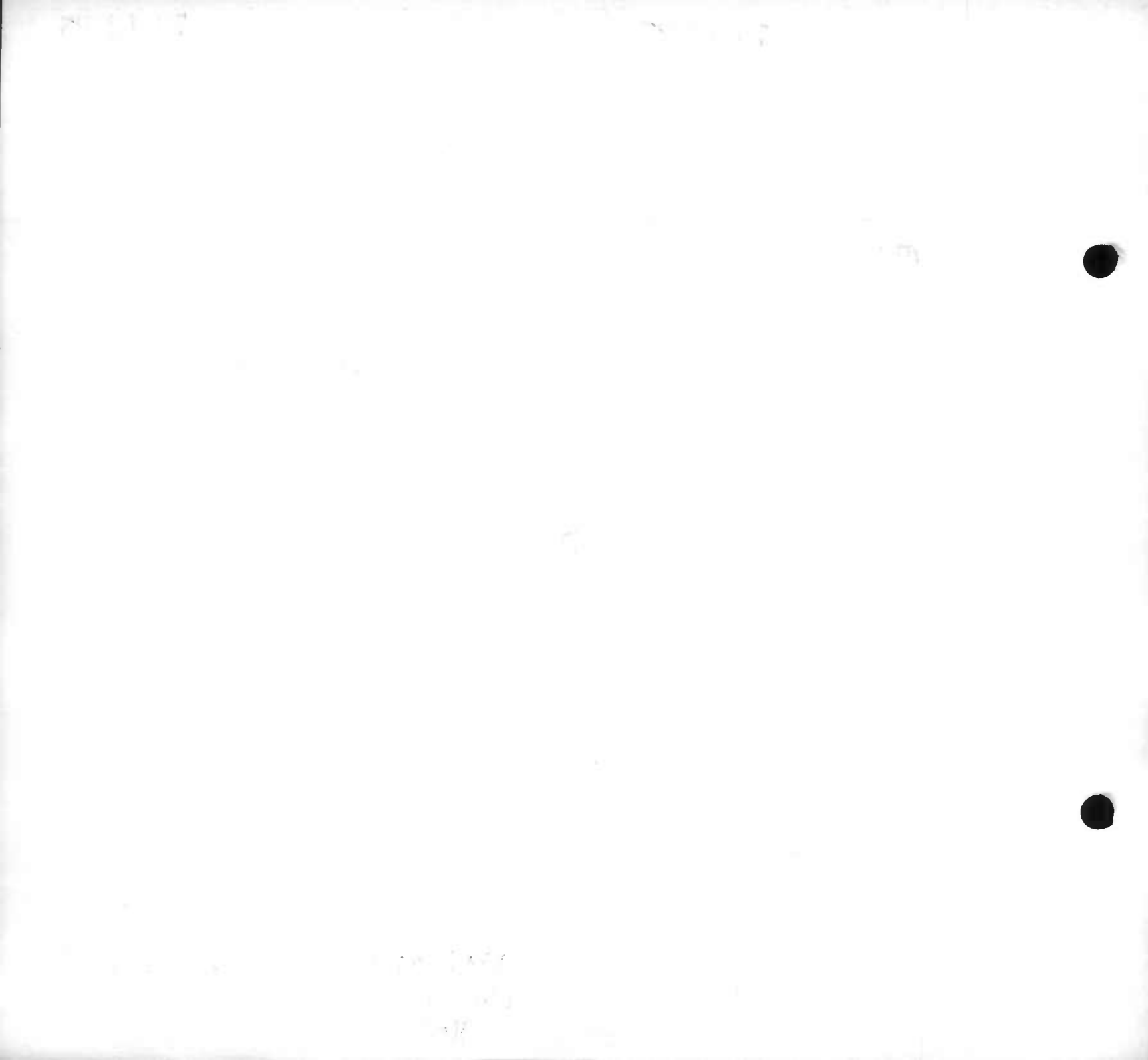
BALTIMORE CITY HEALTH DEPARTMENT				70 12724	
CERTIFICATE OF DEATH				REG. NO. 70 12724	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MRS. JEANNETTE J. SKINNER		2. DATE AND HOUR OF DEATH 12/29/70 12:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL BALTIMORE, MARYLAND 21231			A. STATE MARYLAND		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1539 E. FAYETTE ST 301		
5. SEX F	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/1/15	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Party Helper		10B. KIND OF BUSINESS OR INDUSTRY Merchant Club		11. BIRTHPLACE (State or foreign country) MD. Balto.	
13. FATHER'S NAME JOSEPH SKINNER		14. MOTHER'S MAIDEN NAME HELEN CAULK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 219-16-3075		17. INFORMANT THELMA HALL	
				ADDRESS 210 BETHEL CT.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC FAILURE, MYOCARDIAL INFARCTION, ACUTE DIABETES MELLITUS, URINARY TRACT INFECTION (B) DUE TO, OR AS A CONSEQUENCE OF: ACUTE RENAL FAILURE, OCCLUSION OF FEMORAL ARTERY (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/20 1970 to 12/29 1970 that (I) (we) last saw the deceased alive on 12/29 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. C. Chouvalit, M.D.				23B. DATE SIGNED 12/29/70	
23C. PHYSICIAN'S NAME (Type) A. C. CHOUVALIT, M.D.				23D. ADDRESS Church Home & Hospital Baltimore, Md. 21231	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/4/71		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
				24D. LOCATION (City, town, or county) (State) Balto. Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 31 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Morton & Dept. FH 1701 Laurels St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>70-21911</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 12725</u>	
1. NAME OF DECEASED (Type or Print) <u>Boy "C" GARDNER</u>		2. DATE AND HOUR OF DEATH <u>December 13, 1970 9:10 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>South Baltimore General Hospital</u>		4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1516 Light St 2302</u>	
5. SEX <u>MALE</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/13/70</u>	9. AGE (in years lost birthday) <u>10</u> min	10. If Under 1 Yr. Months: <u>1</u> Days: <u>0</u> Hours: <u>0</u> Min: <u>10</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME <u>Thomas Mitchell Gardner</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Elizabeth Simpkins</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mother</u> ADDRESS <u>1516 Light St</u>	
18. <u>769.4 I</u> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Immaturity of female</u>		<u>10 min</u>	
ANTECEDENT CAUSES		(B) <u>3rd born of triplet</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>12/13/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/13</u> 19 <u>70</u> to <u>12/13</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>12/13</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Sang Y. Rhim, M.D.</u>		23B. DATE SIGNED <u>12/13/70</u>		23C. PHYSICIAN'S NAME (Type) <u>SANG Y. RHIM, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>12-21-70</u>		24B. DATE <u>12-21-70</u>		24C. NAME OF CEMETERY or CREMATION <u>ANATOMY BOARD OF MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, R.S.</u>		25C. FUNERAL DIRECTOR <u>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Underdetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>M-632</span> <span>70 12726</span> </div>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <span style="font-size: 1.2em;">70 12726</span>	
BIRTH NO. <span style="font-size: 1.2em;">M-632</span>			1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">MARY MURDOCK</span>		
2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">12/31/70 3-10 PM</span>			3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <span style="font-size: 1.2em;">Lutheran Hospital of MD</span>		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span>			FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">Lutheran Hospital of MD</span>		
C. CITY OR TOWN <span style="font-size: 1.2em;">BALTO</span>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <span style="font-size: 1.2em;">1501 N. DUKELAND ST. 1607</span>					
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">C</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">7/16/87</span>	9. AGE (In years, last birthday) <span style="font-size: 1.2em;">83</span>	10. If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Elliot City</span>	
12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME <span style="font-size: 1.2em;">James Heron</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Jannie</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <span style="font-size: 1.2em;">Lucie S. Suddeth</span> <span style="font-size: 1.2em;">532 N. Sullivan</span>	
18. <span style="font-size: 1.2em;">43791</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">CEREBRO VASCULAR ACCIDENT.</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">CEREBRAL ARTERIO SCLEROSIS.</span>			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <span style="font-size: 1.2em;">1) URINARY TRACT INFECTION 2) PNEUMONIA 3) CHF</span>					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <span style="font-size: 1.2em;">NO INJURY</span>	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">12/4/1970</span> to <span style="font-size: 1.2em;">12/31/1970</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">12/31/1970</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">K George Thomas MD</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">12/31/70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">K GEORGE THOMAS MD</span>		23D. ADDRESS <span style="font-size: 1.2em;">Lutheran Hospital of MD</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">1-5-71</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Mt. Lebanon</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore MD</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 4 1971</span>		25B. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Robert C. Taylor</span>	
25C. ADDRESS <span style="font-size: 1.2em;">2302 W. Baltimore Blvd</span>					

1871

1. The first of the year was a very dry one, and the crops were much injured by the drought.

2. The second of the year was a very wet one, and the crops were much injured by the rain.

3. The third of the year was a very dry one, and the crops were much injured by the drought.

4. The fourth of the year was a very wet one, and the crops were much injured by the rain.

5. The fifth of the year was a very dry one, and the crops were much injured by the drought.

6. The sixth of the year was a very wet one, and the crops were much injured by the rain.

7. The seventh of the year was a very dry one, and the crops were much injured by the drought.

8. The eighth of the year was a very wet one, and the crops were much injured by the rain.

9. The ninth of the year was a very dry one, and the crops were much injured by the drought.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 70 12727	
P-636 70 12727		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <del>XXXXXXXXXX</del> MARIE PORTER		2. DATE AND HOUR OF DEATH 12/31/70 3:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND BALTIMORE CITY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 803 N. MONTFORD AVENUE 702			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-5-98	9. AGE (in years lost birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ROBERT PORTER		14. MOTHER'S MAIDEN NAME MARY K. RAW	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215 50 9263		17. INFORMANT Miss Marie E. Porter - 803 N. Montford Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Aspirational Pneumonia (B) METASTATIC CARCINOMA (C) UNKNOWN		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 71	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/28 19 70 to 12/31 19 70, that (I) (we) last saw the deceased alive on 12/31 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Knut S. Alfredson		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) KNUTE S. ALFREDSON		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 1-4-71	24C. NAME OF CEMETERY or CREMATORY BALTIMORE CEMETERY		24D. LOCATION (City, town, or county) (State) BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1971	25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Gentry Miller - 2334 Jefferson St.		ADDRESS

15781 U

15782 U

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15784 U

15785 U

U

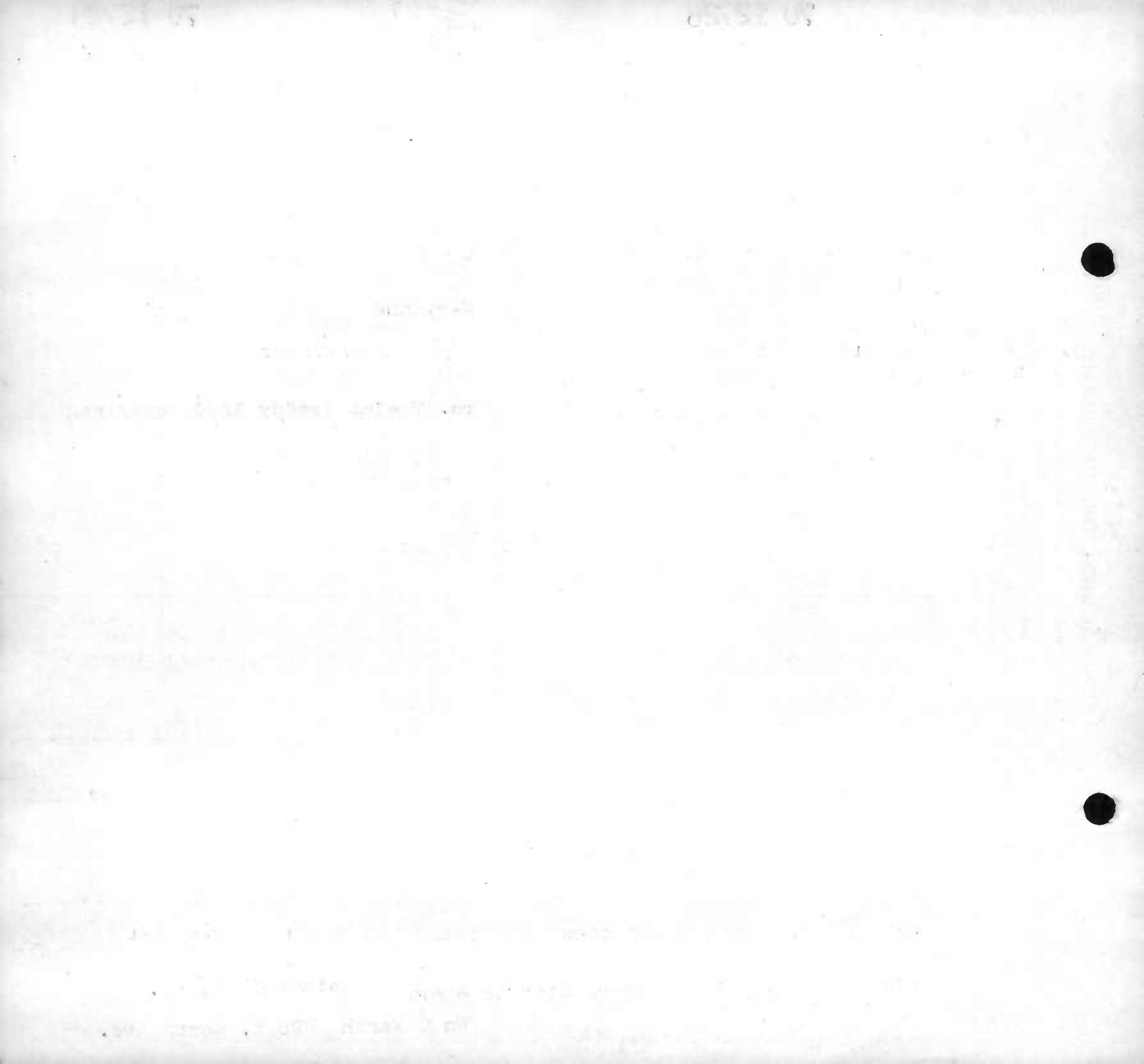
15786 U

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12728</u>	
CERTIFICATE OF DEATH					
BIRTH NO. <u>9-630</u>		1. NAME OF DECEASED (Type or Print) <u>Alyce T. Preddy</u>		2. DATE AND HOUR OF DEATH <u>12/28/70</u> <u>6 AM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <u>Johns Hopkins Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>1526 Homestead ST.</u> <u>907</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>6-13-43</u>	9. AGE (In years last birthday) <u>27</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>NORRIS JONES</u>			14. MOTHER'S MAIDEN NAME <u>THELMA MATTHEWS</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mrs. Thelma Preddy 1526 Homestead</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cachexia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic Curvature</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/27</u> 19 <u>70</u> to <u>12/28</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>12/27</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>James L. Sachsteder</u> OEGREE				23B. DATE SIGNED <u>12/28/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>JAMES L SACHSTEDER</u> OEGREE				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/2/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Western Star Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Catonsville, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 4 1971</u>			
25B. NAME OF REGISTRAR <u>John E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wm C March 928 E. North Ave.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-536		70 12729		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12729	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>MRS. AGATHA ANDERSON</u>				2. DATE AND HOUR OF DEATH <u>DECEMBER 27, 1970</u> <u>11:30</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BON SECOURS HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>CITY</u>			
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1925 PENROSE AVE</u> <u>2001</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/05/03</u>	9. AGE (in years last birthday) <u>67 yrs</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>
13. FATHER'S NAME <u>CHARLES HUTCHINS</u>				14. MOTHER'S MAIDEN NAME <u>Stella SMITH</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Estella Chambers</u>		
					ADDRESS <u>1935 Penrose</u>		
18. <u>1970-81</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>GI - bleeding</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Metastasis Ca liver</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>GI - bleeding</u> (B) <u>Metastasis Ca liver</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>unknown</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>unknown</u> <u>best proved 1 month</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>X NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12-18</u> 19 <u>70</u> to <u>12-27</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>12-27</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Janira Vorraraksa</u>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>JANIRA VORARAKSA</u>	
				23D. ADDRESS <u>BSO</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/2/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Anne Arundel City, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 4 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, Jr.</u>		25C. FUNERAL DIRECTOR <u>Wm C March</u> ADDRESS <u>928 E. North Ave.</u>			



# FUNERAL DIRECTOR: IMPORTANT

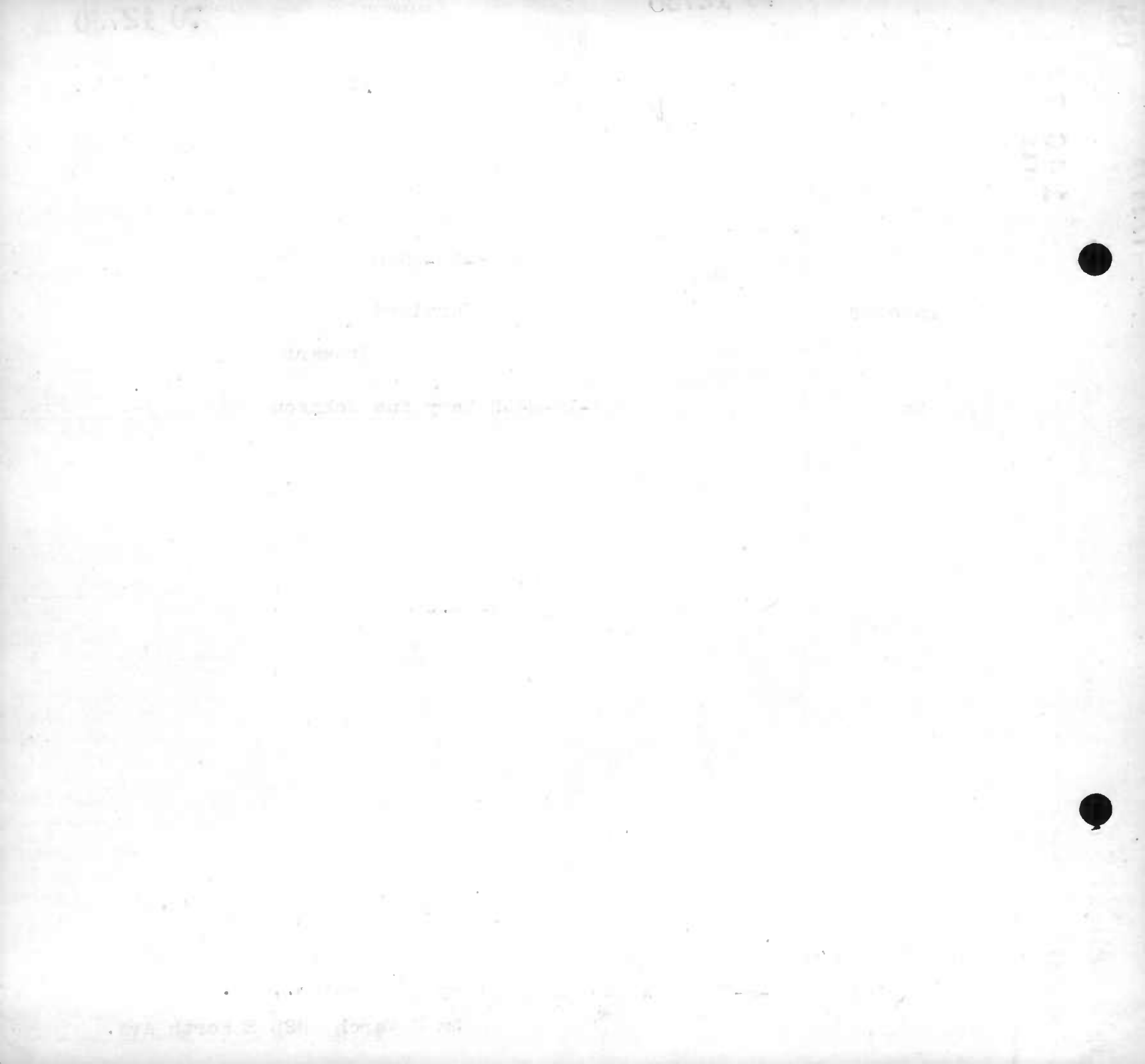
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 70 12730

G-420

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		FREEMAN GILES		12-30-70 10.40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND B. COUNTY BALTIMORE CITY			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1604 GREENMOUNT AVENUE 1205			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-20-1900	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME PETER GILES		14. MOTHER'S MAIDEN NAME CLARA Stewart			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-12-9493		17. INFORMANT Mary Sue Johnson 430 E 21st St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Acute Myocardial Infarct DUE TO, OR AS A CONSEQUENCE OF: ISCVD		2d	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anthony S. Jennings				23B. DATE SIGNED 12-31	
23C. PHYSICIAN'S NAME (Type) ANTHONY S. JENNINGS				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-5-71		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
				24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1971		25B. NAME OF REGISTRAR Wm C March		25C. FUNERAL DIRECTOR 928 E North Ave.	



BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 12731

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>THELMA D. PULLEY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M. 3. DATE PRONOUNCED DEAD Month Day Year Hour December 30, 1970 4:23 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
6. SEX <b>Female</b>	7. RACE <b>Negro</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>12/17/23</b>		10. AGE (In years lost birthday) <b>47</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Laucis McCray</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY <b>Eunice Boykin</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>Mr. Jucute Pulley 1254 N Broadway</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Fatty Metamorphosis of Liver</b>  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)	
20A. DATE OF OPERATION <b>12/30/70</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>21. AUTOPSY? (Yes or No)</b> <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?</b>	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/2/71</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Cty., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Wm C March</b>		ADDRESS <b>928 E. North Ave.</b>	

James H. Brown

James H. Brown

Mr. Brown, 1001 N. 1st St.

James H. Brown

James H. Brown

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED  
(Type or Print)

Patricia Curtis (Rucker)

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Hopkins Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

12

26

70

10:44 a

M.

5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)

A. STATE

Maryland

B. COUNTY

6. SEX

female

7. RACE

colored

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

12/12/70

10. AGE (In years  
lost birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

14

E. STREET AND NUMBER

339 E. 22nd St.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

CLIFTON CURTIS

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

VIOLET RUCKER

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

MR CLIFTON CURTIS 1823 E. FEDERAL ST

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Sudden death in infancy  
DUE TO, OR AS A CONSEQUENCE OF:ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A.

DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A.

EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/27/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

12/29/70

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 4 1971

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JVA &amp; MARCH 928 E. NORTH AVE

STATE OF

STATE OF

IN SENATE

January 1, 1901

REPORT

OF THE

COMMISSIONER

OF THE

LANDS

AND

WATERS

OF THE

STATE

OF

NEW YORK

FOR

THE YEAR

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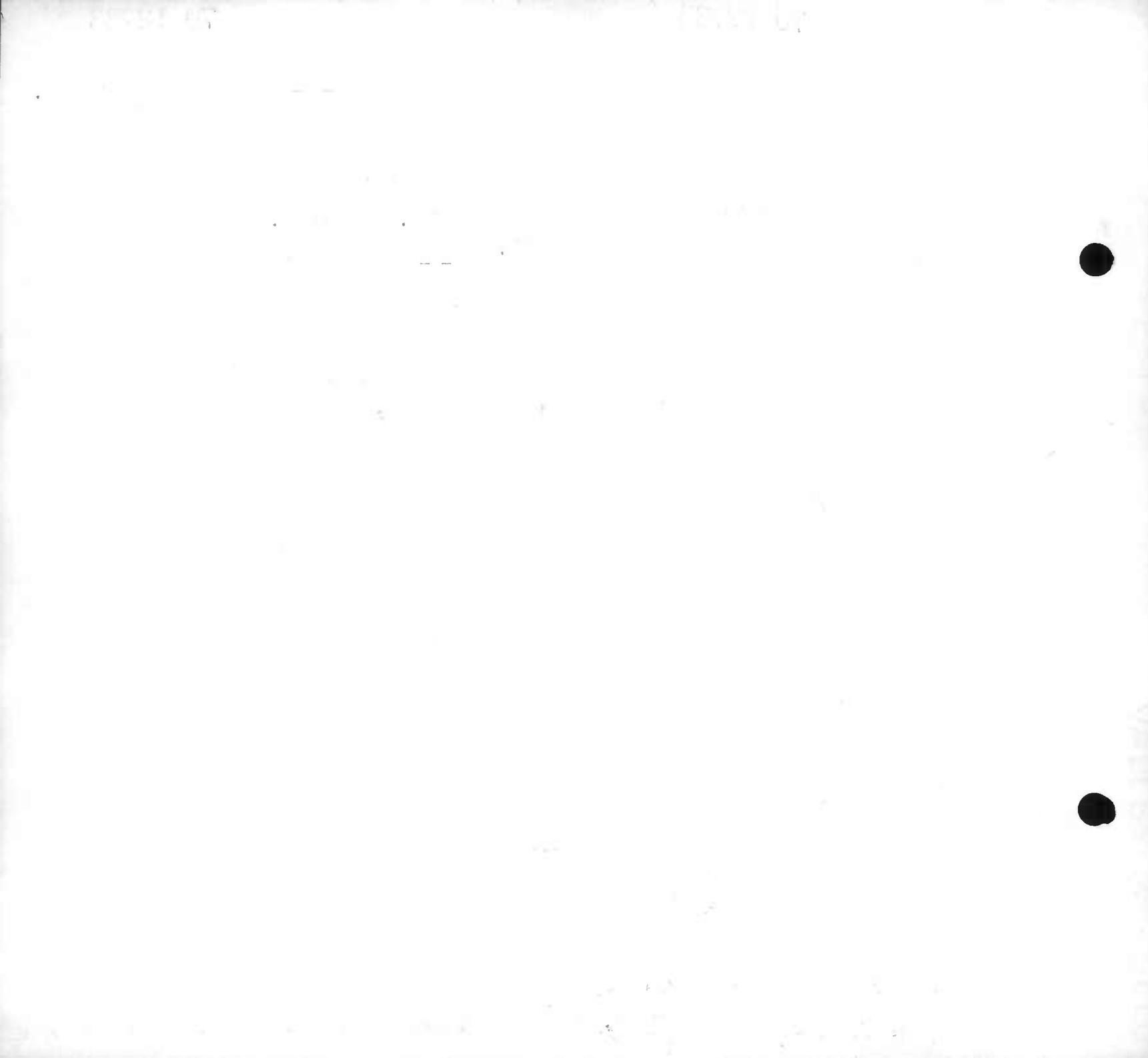
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12733	
L-250 70 12733					
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Henry Logan			
2. DATE AND HOUR OF DEATH 12-28-70 6 a.m.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 747 E. Preston St. 1001		5. SEX Male 6. RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 11-8-46 9. AGE (in years last birthday) 24 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Leonard Logan		14. MOTHER'S MAIDEN NAME Ethel Terry			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-44-7853		17. INFORMANT ADDRESS ARNETTA MCCOY 2757 TIVOLY AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE HEMORRHAGIC DIARRHEA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. FATTY INFILTRATION OF LIVER		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) FATTY INFILTRATION OF LIVER DUE TO, OR AS A CONSEQUENCE OF: (C) ...		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (We) (this hospital) attended the deceased, from 12/26/70 to 12/28/70, that (we) last saw the deceased alive on 12/28/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED 12/28/70		23C. PHYSICIAN'S NAME (Type) [Signature]	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/4/71		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.	
24D. LOCATION (City, town, or county) (State) Anne Arundel City, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 4 1971		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR WMC MARCH		25D. ADDRESS 928 E. NORTH AVE			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **70 12734**

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				<b>70 12734</b>		<b>12-29-70</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
<b>1534 N. Wolfe St.</b>				<b>Maryland</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				<b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location)			
				<b>1534 N. Wolfe Street</b>			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
<b>Female</b>	<b>Negro</b>	<b>Widowed</b>	<b>8-2-08</b>	<b>62</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<b>Housewife</b>					<b>Maryland</b>		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>James Henry</b>				<b>Rosie Claughton</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				<b>Mrs. Rose Lockett</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
I		<b>Myocardial Infarction</b>				<b>12-29-70</b>	
ANTECEDENT CAUSES		(B) <b>Hypertensive Atherosclerotic heart disease</b>				<b>9-22-60</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <b>Idiopathic Epilepsy</b>				<b>1955</b>	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/22</b> 19 <b>60</b> to <b>12-15-</b> 19 <b>70</b> , that (I) (we) lost saw the deceased alive on <b>12-15-</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
<b>T.D. Thifer</b>				<b>1/2/71</b>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
<b>T.D. Thifer</b>				<b>1228 N. Guilford St</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>1-4-71</b>		<b>Mt Calvary Cemetery</b>		<b>Anne Arundel Cty., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR'S ADDRESS			
<b>JAN 4 1971</b>		<b>Robert E. Taylor, M.D.</b>		<b>Wm C March</b>		<b>928 E. North Ave.</b>	

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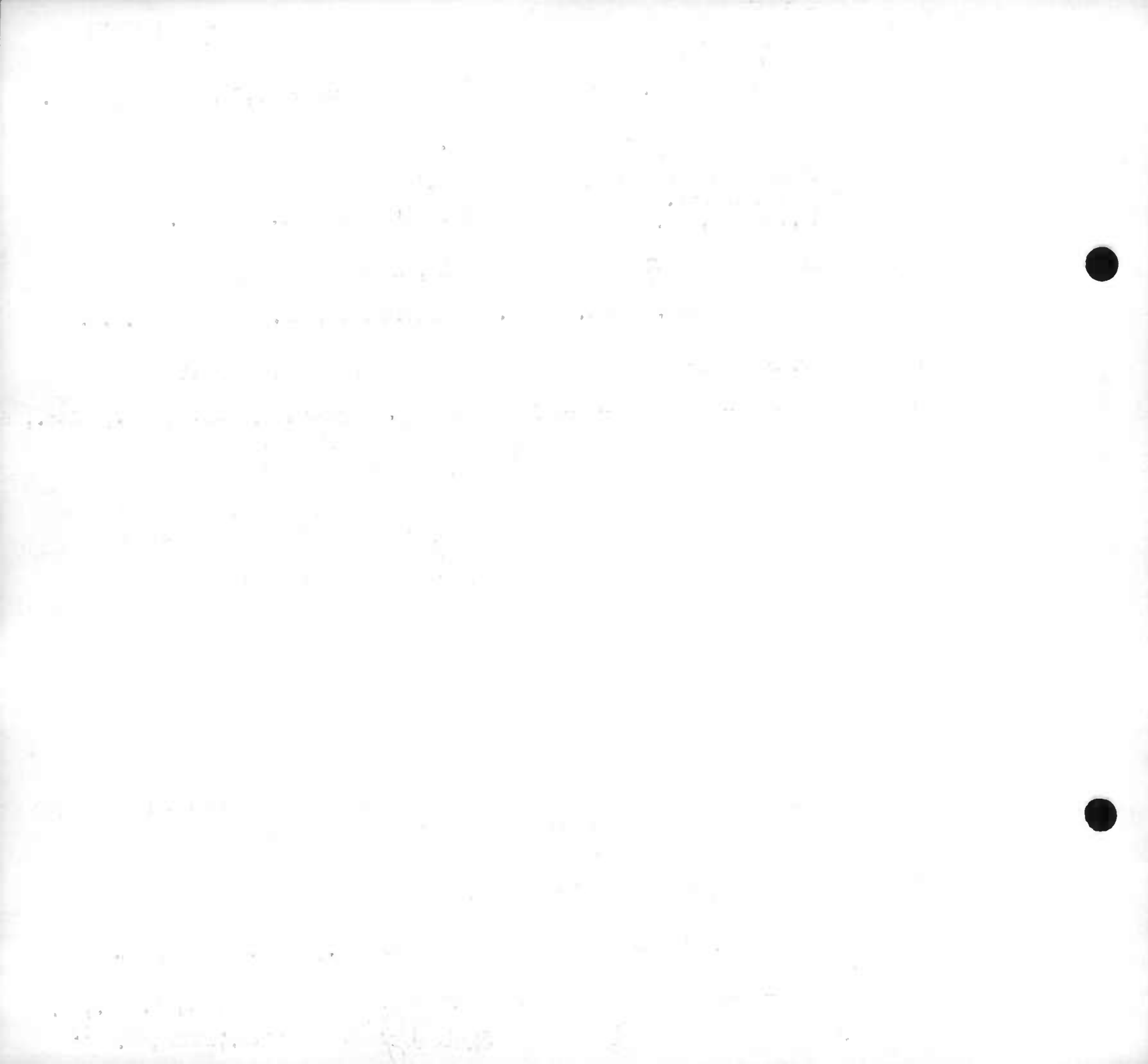
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

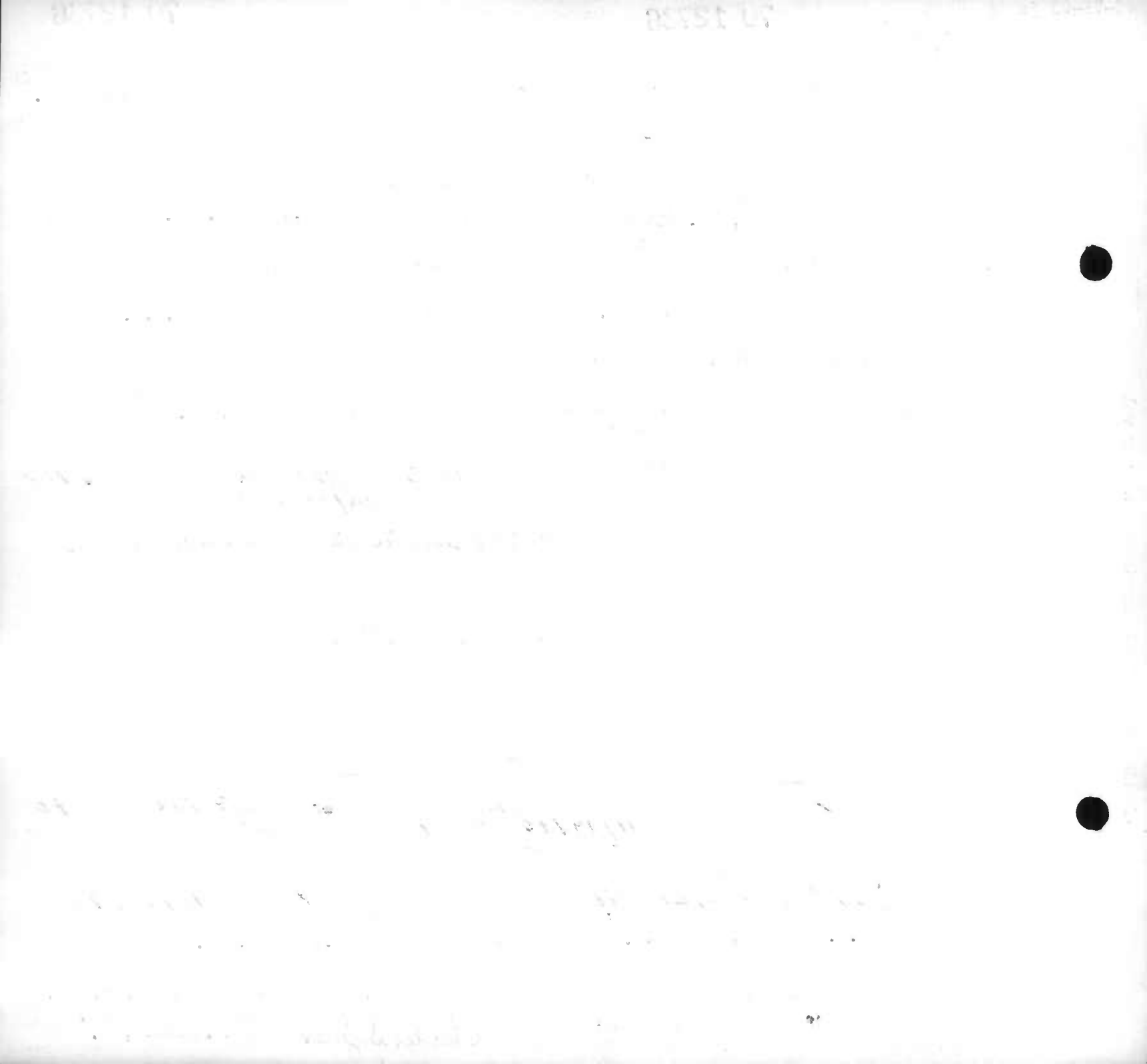
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 12735</u>	
BIRTH NO. <u>W-256</u>		70 12735	
1. NAME OF DECEASED (Type or Print) <u>WILLIAM R. WAGNER</u>		2. DATE AND HOUR OF DEATH <u>December 27, 1970</u>   <u>6:30 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Balto., 21224, Md.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3303 O'Donnell St. # 21224.</u> <u>2611</u>	
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1888</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Amer. Smelt. &amp; Ref.</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
13. FATHER'S NAME <u>Peter Wagner</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Cupinski</u>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-10-1872</u>	17. INFORMANT ADDRESS <u>William D. Wagner: 7309 Kirtley Rd., Balto., Md.</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Coronary artery disease.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Generalized arteriosclerosis and myocardial damage.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Diabetes mellitus (late).</u> (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <u>12-20-70</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <input type="checkbox"/>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/26/59</u> to <u>12/21</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>12/4</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (died) (did not) view the body after death.			
23A. SIGNATURE <u>Edward A. Flanigan, Jr.</u>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>EDWARD A. FLANIGAN, JR.</u>		23D. ADDRESS <u>3501 Fait Ave., Balto., 21224, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>12-31-70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>7225 Eastern Blvd., Ba. Co., Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 4 1971</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>	25C. FUNERAL DIRECTOR <u>Charles S. Zeller</u>	ADDRESS <u>901 S. Conkling St./ Balto., 21224, Md.</u>



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12736		BALTIMORE CITY HEALTH DEPARTMENT		70 12736	
CERTIFICATE OF DEATH				REG. NO.	
K-656		BIRTH NO.			
1. NAME OF DECEASED (Type or Print)		Barbara Koerner (BARBARA H. KOERNER)		2. DATE AND HOUR OF DEATH 12-27-70 11:26 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Md. 21224		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Housewife		At Home.		10-2-95	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (in years last birthday)	
Valentine Horst		Catherine Jenkins		75	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)	
No		212-01-0878		Maryland	
17. INFORMANT		ADDRESS		12. CITIZEN OF WHAT COUNTRY?	
BCH Records:		4940 Eastern Avenue Baltimore, Md. 21224		U.S.A.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Approx 1 hr	
ANTECEDENT CAUSES		(B) Arteriosclerotic cardiovascular dis		Unknown	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Diabetes Mellitus			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
0					
21D. TIME OF INJURY (APPROX)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from July 1969 to 27 Dec 1970 that (I) (we) last saw the deceased alive on 11/19/70 1970 and that (in) (my) (our) applan death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
S.W. Douglas, III, M.D.		12/28/70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
S.W. Douglas, III M.D.		Baltimore City Hospitals 4940 Eastern Ave., Balto. Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12-31-70		Oak Lawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 4 1971		Robert E. Baker, M.D.		Charles S. Siler	
25D. LOCATION (City, town, or county) (State)		25E. ADDRESS			
7225 Eastern Blvd., Ba. Co., Md.		6224 Eastern Ave. Balto., 21224, Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-400		70 12737		BALTIMORE CITY HEALTH DEPARTMENT		70 12737	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <i>John J. Doyle Sr.</i>				2. DATE AND HOUR OF DEATH <i>Dec 30, 1970</i> <i>7:15</i> <i>P</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Harbor View Nursing Home</i> <i>1213 Light St Balto Md</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>Balto city</i>			
5. SEX <i>M</i> 6. RACE <i>W</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>8/15/82</i>		9. AGE (in years last birthday) <i>88</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Navy (Retired)</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Rhode Island</i>	
13. FATHER'S NAME <i>John W. Doyle</i>				14. MOTHER'S MAIDEN NAME <i>Alecia <del>Stewart</del> A. Welsh</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes</i>				16. SOCIAL SECURITY NO. <i>219-28-3598</i>		17. INFORMANT <i>John Doyle Jr.</i> <i>155-4 Eagle Rd (son)</i>	
18. <i>43371</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>CVA</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>Cerebral Artery Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>DEC. 16</i> 19 <i>70</i> to <i>DEC. 30</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>DEC. 30</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Helen Ann Anderson</i>				23B. DATE SIGNED <i>12-31-70</i>		23C. PHYSICIAN'S NAME (Type) <i>ROLEND SABUNDAYO</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>1/4/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>				25A. DATE REC'D BY HEALTH DEPT. <i>JAN 4 1971</i>			
25B. NAME OF REGISTRAR <i>Robert J. Ruck</i>				25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>			

1/15/71 - Correction form from General Director.  
LBC.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-630		70 12738		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12738	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>BERTHA</b>				WARD		2. DATE AND HOUR OF DEATH <b>Dec. 29, 1970 1 1.00 a.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>LONG GREEN NURSING HOME</b> <b>115 E. Melrose Avenue</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>943 Montpelier St.</b>		<b>904</b>	
5. SEX <b>female</b>	6. RACE <b>caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 8 1886</b>	9. AGE (In years last birthday) <b>84</b>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>August Olfers</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Maxwell</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213 50 6907</b>		17. INFORMANT <b>Mrs. Frances Maxwell</b> ADDRESS <b>3615 Ednor Rd Baltimore, Md 21218</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>arteriosclerotic Degenerative C.V. Disease, Arrhythmia, Fibrillation years.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Coronary Insufficiency &amp; Sclerosis</b> <b>Acute heart failure.</b> <b>Emphysema</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>19 55</b> to <b>December 19 70</b> that (I) (we) last saw the deceased alive on <b>14 Dec 19 70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Joseph E. Muse J.M.D.</b>						23B. DATE SIGNED <b>12/30/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Joseph E. Muse</b>				23D. ADDRESS <b>2725 N. Charles St, Balto, Md.-18</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-2-71</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.-Balto, Md.-14</b>		ADDRESS	



70 12739

VS 151-REV. 7/1/68

## MEDICAL CERTIFICATION

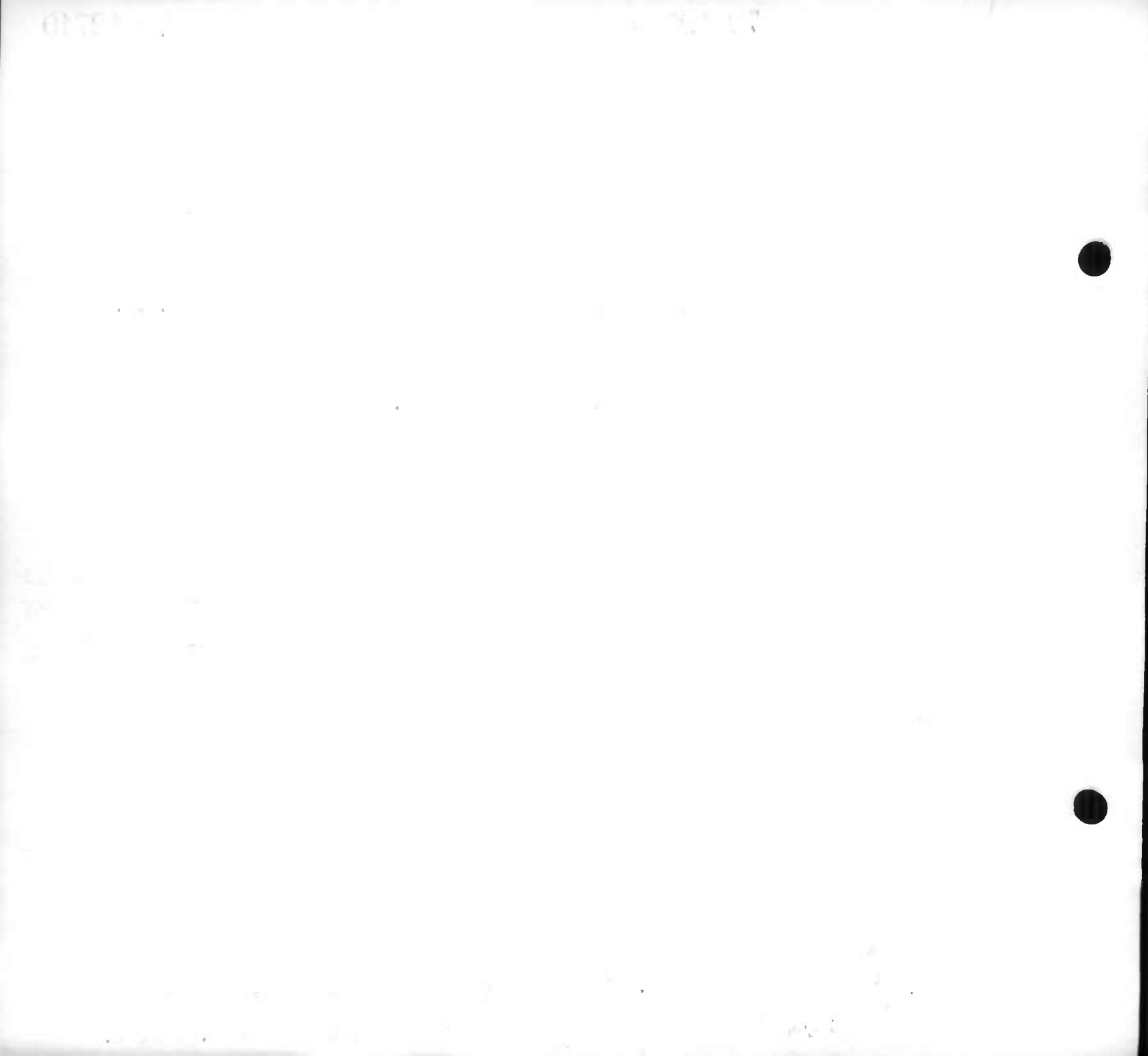
10 15190

10 15190

ACADEMIC RECORDS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>BIRTH NO.</b> <span style="font-size: 1.5em;">M-525</span> <span style="font-size: 1.5em;">70 12740</span></p> <p style="text-align: right;"><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p> <p style="text-align: right;"><b>REG. NO.</b> <span style="font-size: 1.5em;">70 12740</span></p>			
<p><b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Mamie C. Munson</span></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">Dec. 29, 1970</span>   <span style="font-size: 1.2em;">10<sup>50</sup></span> P.M.</p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">South Baltimore General Hospital</span></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY _____</p>	
<p><b>5. SEX</b> <span style="font-size: 1.2em;">F.</span> <b>6. RACE</b> <span style="font-size: 1.2em;">W.</span></p>		<p><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p><b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">9-20-'94</span> <b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">76</span></p>		<p><b>10. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span> <b>11. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span></p>	
<p><b>12. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span> <b>13. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span></p>		<p><b>14. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span> <b>15. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span></p>	
<p><b>16. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span> <b>17. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span></p>		<p><b>18. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span> <b>19. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span></p>	
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> -----</p>	
<p><b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Phillip Vetter</span></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Minnie Meister</span></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span></p>		<p><b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">216-28-7914</span></p>	
<p><b>17. INFORMANT</b> <span style="font-size: 1.2em;">Thomas K. Munson</span></p>		<p><b>ADDRESS</b> <span style="font-size: 1.2em;">same</span></p>	
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Pneumonia, ASCVD</span></p>		<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">10 days to 4 M.</span></p>	
<p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p><b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <span style="font-size: 1.2em;">C.H.F. Diabetes Mellitus</span></p>	
<p><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> -----</p>		<p><b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b> -----</p>	
<p><b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>			
<p><b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">8/29/70</span></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> -----</p>	
<p><b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">No</span></p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> -----</p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) -----</p>	
<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) -----</p>		<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.) -----</p>	
<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b> -----</p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">Dec. 26</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">Dec. 29</span> 19 <span style="font-size: 1.2em;">70</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">Dec. 29</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Susumu Kinjo MD.</span></p>		<p><b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">Dec. 29, 1970</span></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Susumu Kinjo MD.</span></p>		<p><b>23D. ADDRESS</b> <span style="font-size: 1.2em;">3001 South Hanover Str. Baltimore, MD. 21225</span></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span></p>		<p><b>24B. DATE</b> <span style="font-size: 1.2em;">1/2/71</span></p>	
<p><b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Mt. Olivet Cemetery</span></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">JAN 4 1971</span></p>		<p><b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Taylor, MD.</span></p>	
<p><b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">McCully Funeral Home 130 E. Fort Ave.</span></p>		<p><b>ADDRESS</b> -----</p>	



58-17-13 d]s

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

58-17-13 d]s		70 12741		BALTIMORE CITY HEALTH DEPARTMENT		70 12741	
S-552		SIHANIK		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Judwika Szymanik</i>				2. DATE AND HOUR OF DEATH <i>12/25/70</i> <i>2:05 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Baltimore City Hospital</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i> 6. RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>11/17/86</i>		9. AGE (in years last birthday) <i>84</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Poland</i>	
13. FATHER'S NAME <i>Jacob</i>				14. MOTHER'S MAIDEN NAME <i>Marcella</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>218-10-5537</i>		17. INFORMANT <i>4940 Eastern Avenue</i> <i>BCH: Records Baltimore, Maryland 21224</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac arrest &amp; toxemia</i> (B) <i>Septic shock</i> (C) <i>UTI, sepsis, diabetic ketoacidosis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Dec. 24</i> 19 <i>70</i> to <i>Dec. 25</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>Dec. 25</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>J. L. Fleg M.D.</i>				23B. DATE SIGNED <i>12/25/70</i>			
23C. PHYSICIAN'S NAME (Type) <i>J. L. Fleg M.D.</i>				23D. ADDRESS <i>Baltimore City Hospitals 21224</i> <i>4940 Eastern Avenue Baltimore, Maryland</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-29-70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Rosary Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 4 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Fleg, M.D.</i>		25C. FUNERAL DIRECTOR <i>B. Dabrowski</i>		ADDRESS <i>2816 E. BALTIMORE ST.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>W-420</b>		BALTIMORE CITY HEALTH DEPARTMENT		70 12742		CERTIFICATE OF DEATH		REG. NO. <b>70 12742</b>	
1. NAME OF DECEASED (Type as Print) <b>WALLACE, MARY FRANCES</b>				2. DATE AND HOUR OF DEATH <b>12 29 70</b>		8:45A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST AGNES HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>FEMALE</b>				6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3 17 04</b>	
9. AGE (In years last birthday) <b>66</b>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA, Norfolk</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>? Brown</b>				14. MOTHER'S MAIDEN NAME <b>NELLIE MC NULTY</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>CATON BALTO MD 21229</b> <b>ST <del>XXXX</del> AGNES HOSP RECORDS WILKENS &amp;</b>					
18. <b>4-31-70</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Brain Stem Hemorrhage</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Brain Stem Hemorrhage</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15-20 hrs</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				(B) _____ DUE TO, OR AS A CONSEQUENCE OF:				(C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (X) (this hospital) attended the deceased from <b>12 28 19 70</b> to <b>12 29 19 70</b> that (X) (we) lost saw the deceased alive on <b>12 29 19 70</b> and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (and not) view the body after death.									
23A. SIGNATURE <b>David A. Perry, M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12/29/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>David A. Perry</b>				23D. ADDRESS <b>St. Agnes Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/31/70</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Sterling Funeral Estate</b> <b>736 Edmondson Ave.</b> <b>Catonville, Md. 21228</b>					

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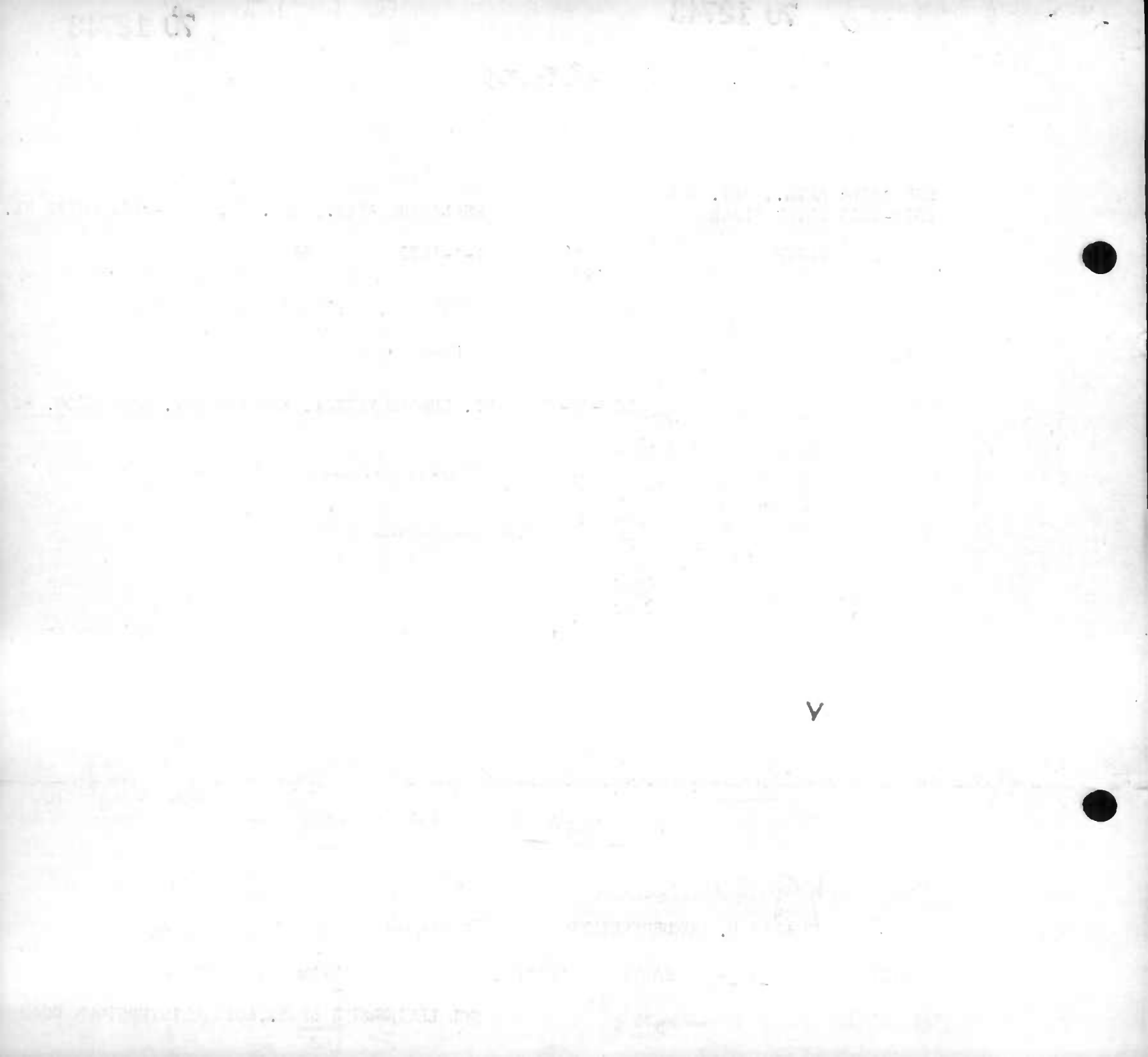
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>70 12743</b>	
BIRTH NO. <b>C-500 70 12743</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>BERTIE COHEN.</b>		2. DATE AND HOUR OF DEATH <b>Dec 26, 1970 4 A. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ESPLANADE APTS., APT. 3 G 2519-2525 EUTAW PLACE</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>ESPLANADE APTS., APT. 3G, 2519-2525 EUTAW PL.</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-1-1875</b>
9. AGE (In years last birthday) <b>95</b>		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ELEAZER COHEN</b>		14. MOTHER'S MAIDEN NAME <b>EMMA FRANK</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-46-3729</b>	
17. INFORMANT <b>MR. EDWARD PUTZEL, 303 1st NAT. BANK BLDG. #2</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerosis</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last. <b>(B) Arteriosclerosis</b> <b>(C) Fractured pelvis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hr</b> <b>1 month</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Fractured pelvis</b>			
19A. DATE OF OPERATION <b>Dec 18, 1970</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fractured pelvis</b>	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>2519-2525 Eutaw Place</b>		21D. TIME OF INJURY (APPROX.) <b>2:00</b>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>fell at home</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>19 50</b> to <b>Dec 26, 1970</b> , that (I) (we) last saw the deceased alive on <b>Dec 18, 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Herbert N. Gundersheimer</b>		23B. DATE SIGNED <b>12-26-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>HERBERT N. GUNDERSHEIMER</b>		23D. ADDRESS <b>Temple Gardens Arts</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-28-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>BALTIMORE HEBREW,</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1971</b>		25B. NAME OF REGISTRAR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
S-550		70 12744		70 12744	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
SIMMONS, Walter L		12/30/70		10:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION CENTURY HOME, Inc 102 N. Paca St. Balto Md 21201		A. STATE Maryland			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Balto		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1310 Edmondson Ave.		1602	
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/23/82	9. AGE (In years last birthday) 88	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
13. FATHER'S NAME MARTIN SIMMONS		14. MOTHER'S MAIDEN NAME LEAH		12. CITIZEN OF WHAT COUNTRY? U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217 56 7983		17. INFORMANT MRS HAXIE WILLIAMS, 2101 Callow Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardio-Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure (B) Antecedent Cause DUE TO, OR AS A CONSEQUENCE OF: Gen + Cerebral Arteriosclerosis (C) Other Significant Conditions Contributing to the Death but Not Related to the Terminal Disease or Condition Given in Part I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 12 1967 to Dec 30 1970 that (I) (we) last saw the deceased alive on Dec 30 1970 and that (in my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Willard Applefeld		23B. DATE SIGNED 12/30/70			
23C. PHYSICIAN'S NAME (Type) Willard Applefeld		23D. ADDRESS 6615 Reisterstown Rd			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/4/71		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A A County MD		25A. DATE REC'D BY HEALTH DEPT. JAN 4 1971		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Adolphus Halstead		25D. ADDRESS 1206 W North Ave			



FUNERAL DIRECTOR: IMPORTANT

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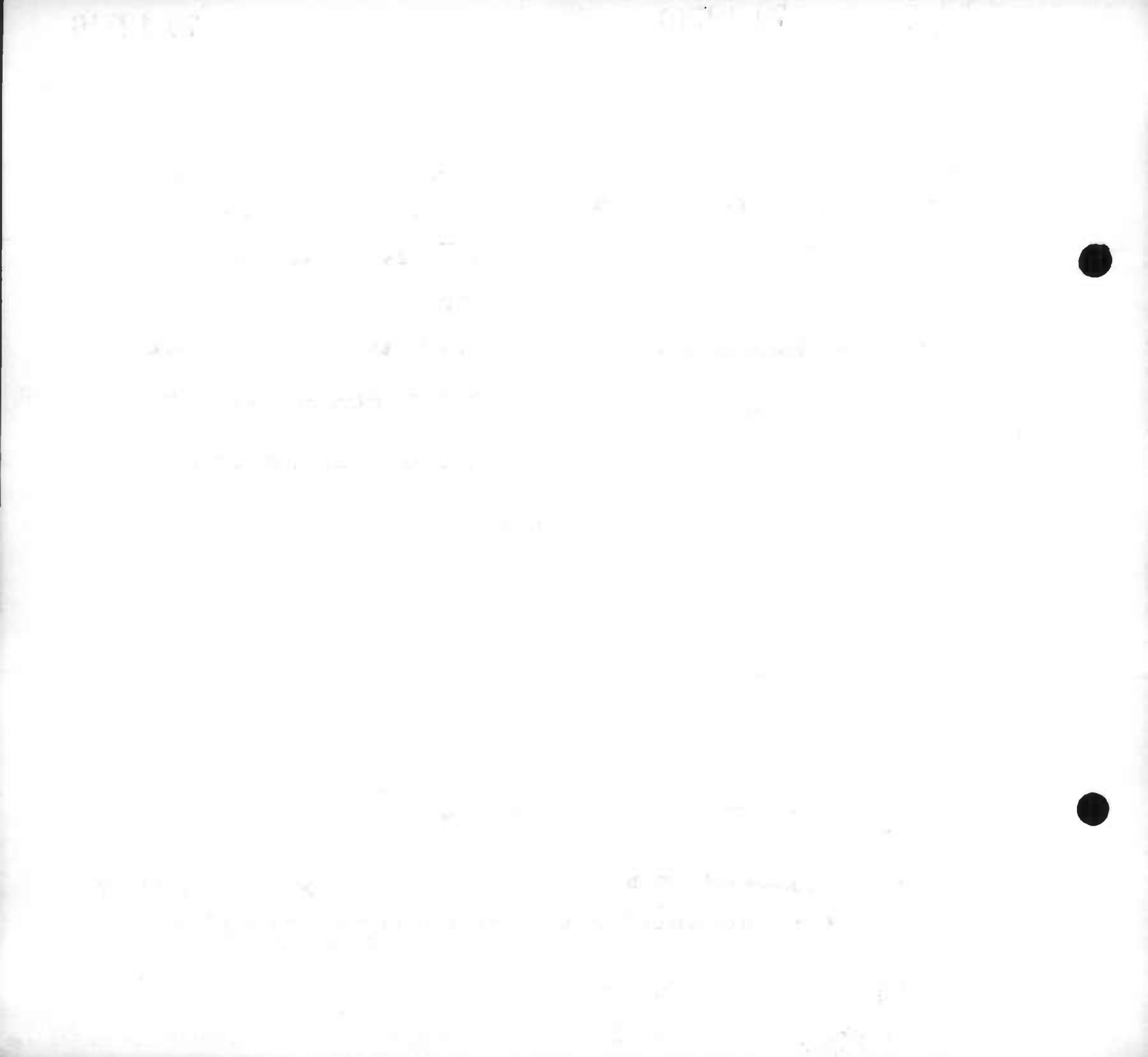
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 12745</b>	
BIRTH NO. <b>70 12745</b>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>PAPADAKIS ARGYRO</b>			2. DATE AND HOUR OF DEATH <b>12-27-70 1:15 P.M.</b>		
3. PLACE IN <b>BALTIMORE, MARYLAND</b> , WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>BOLTON HILL NURSING CENTER</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BOLTON HILL NURSING CENTER</b>			E. STREET AND NUMBER <b>4821 BOWLAND AVE</b>		<b>2652</b>
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1886</b>		9. AGE (In years last birthday) <b>84</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>GREECE</b>	
13. FATHER'S NAME <b>Tony Arnides</b>			14. MOTHER'S MAIDEN NAME <b>Irene</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-54-1902</b>		17. INFORMANT <b>ADMISSION RECORD</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>240.12</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cognitive heart failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>			(B) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF: <b>years</b>		(C) <b>Islets</b> <b>years</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>12/27/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7/16</b> 19 <b>67</b> to <b>12/27</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>12/27</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>ALAN H. MACHT MD</b>				23B. DATE SIGNED <b>12/28/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALAN H. MACHT MD</b>				23D. ADDRESS <b>2E Real St Baltimore 21012</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-30-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Greek Orthodox Cemetery Baltimore, Md.</b>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1971</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor MD</b>		25C. FUNERAL DIRECTOR <b>Nicholas T. Matthews</b>		ADDRESS <b>3021 Eastern Ave., Baltimore, Md.</b>	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12746	
B-622 70 12746				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MR. WALTER E. BRZOWSKI		2. DATE AND HOUR OF DEATH 12/29/90 4:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND. B. COUNTY Baltimore		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL BALTIMORE, MARYLAND 21231		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 8038 WALLACE RD. 5300	
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/13/25	9. AGE (In years last birthday) 45 yrs.	10. Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storeroom Clerk		10B. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH BRZOWSKI		14. MOTHER'S MAIDEN NAME FRANCES NOWAKOWSKI	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] Yes World War II		16. SOCIAL SECURITY NO. 213-20-3494		17. INFORMANT EDWARD BRZOWSKI	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 431.01 SUBARACHNOID HEMORRHAGE.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HYPERTENSION.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 12/29 1990 to 12/29 1990.		that (I) (we) last saw the deceased alive on 12/29 1990 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE A.C. Chouvalit, M.D.		23B. DATE SIGNED 12/29/90		23C. PHYSICIAN'S NAME (Type) A.C. CHOUVALIT, M.D.	
23D. ADDRESS CHURCH HOME & HOSPITAL BALTIMORE, MARYLAND 21231		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-31-90	
24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. JAN 4 1991	
24F. NAME OF REGISTRAR Robert E. Fisher, M.D.		24G. FUNERAL DIRECTOR Nicholas J. Matthews		24H. ADDRESS 3021 Eastern Ave., Baltimore, Md.	



F-600

70 12747

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 12747

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>ERNEST E. FORE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1260 Washington Blvd.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 25 1970 5:50 a</b> M.	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>AUG. 14 - 1915</b>		10. AGE (In years last birthday) <b>55</b>	
11. BIRTHPLACE (State or foreign country) <b>UNION S. CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY	
15. MOTHER'S MAIDEN NAME <b>SUSAN - UNKNOWN</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
17. SOCIAL SECURITY NO. <b>248-10-6974</b>		18. INFORMANT <b>MERIE FORE</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>412.4</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>12-25-70</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
24B. DATE <b>12/29/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>GLEN HAVEN CEM.</b>	
24D. LOCATION (City, town, or county) (State) <b>RITCHIE Highway GLEN BORNIE MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1971</b>	
25B. NAME OF REGISTRAR <b>Robert E. ...</b>		25C. FUNERAL DIRECTOR <b>BRÄUSE 01216 S CHARLES ST.</b>	

WYSE, G.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Thorton Troyer		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 28 70 4:40 p.m.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 3-1-1917		10. AGE (in years lost birthday) 53	
11. BIRTHPLACE (State or foreign country) PENN. PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Maryland B. COUNTY	
15. MOTHER'S MAIDEN NAME UNKNOWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.II	
17. SOCIAL SECURITY NO.		18. INFORMANT MARTIN FRIEDL-216 S. SHARP ST. Md.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty alteration of liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 12/29/70	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/30/70	
24C. NAME OF CEMETERY or CREMATORY GLEN HAVEN CEMETERY		24D. LOCATION (City, town, or county) (State) RITCHIE HIGHWAY GLENDURNI Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR KRAUSE FUNERAL HOME		ADDRESS 1216 S CHARLES ST	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

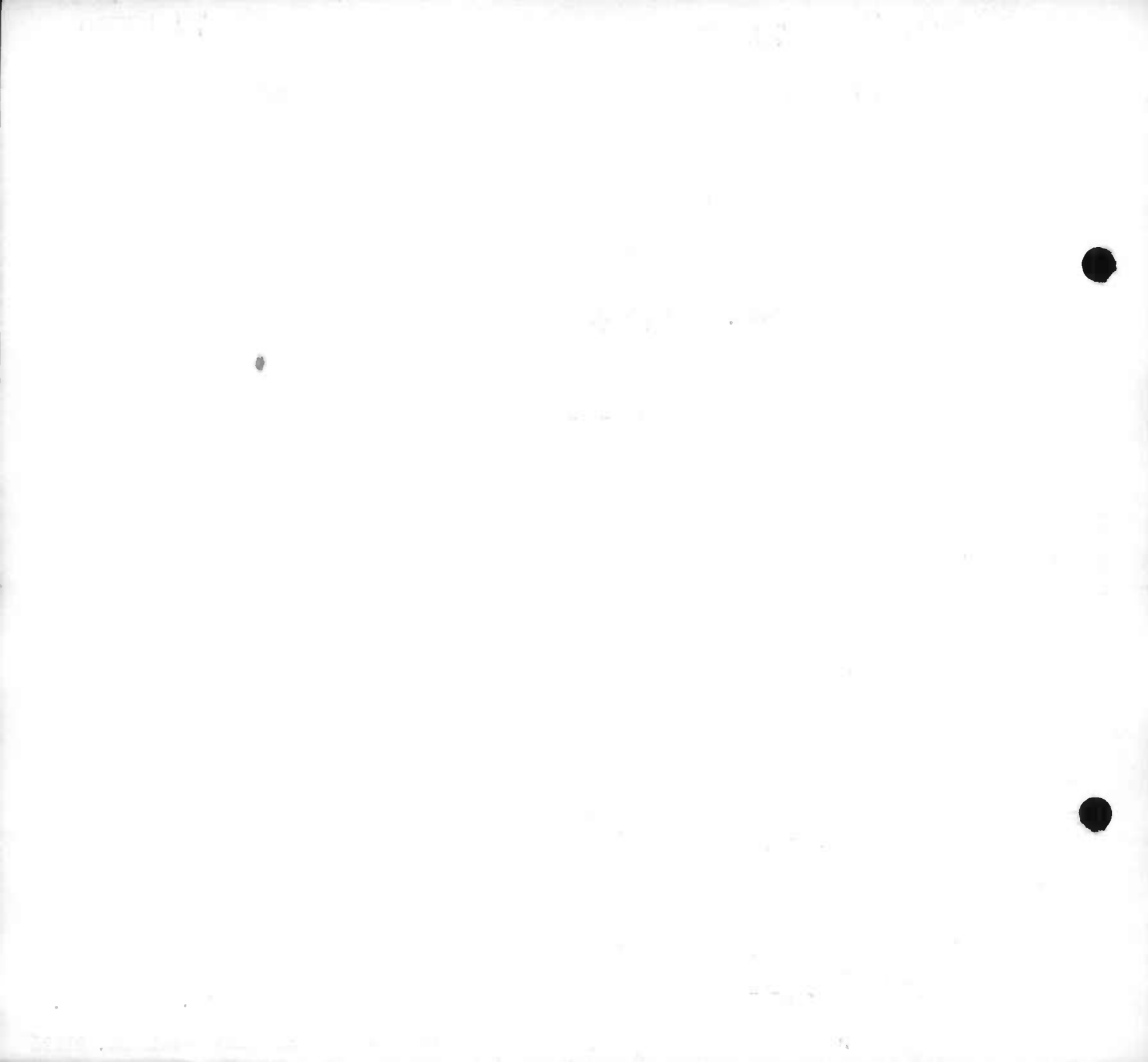
<div style="display: flex; justify-content: space-between;"> <span><b>70 12749</b></span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="display: flex; justify-content: space-between;"> <span><b>CERTIFICATE OF DEATH</b></span> <span>REG. NO. <b>70 12749</b></span> </div>			
<b>BIRTH NO.</b> <span style="font-size: 2em;">K-263</span>		<b>2. DATE AND HOUR OF DEATH</b> DECEMBER 29, 1970 1:00 A. M.	
<b>1. NAME OF DECEASED</b> (Type or Print) <b>RICKERDS, MARIE ANN</b>		<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVENUES BALTIMORE MARYLAND 21229</b>	
<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>5. STREET AND NUMBER</b> <b>7 N MORERICK AVENUE</b>	
<b>5. SEX</b> FEMALE	<b>6. RACE</b> WHITE	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> 11 23 99
<b>9. AGE</b> (In years lost birthday) <b>71</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) SALES LADY	<b>11. BIRTHPLACE</b> (State or foreign country) MARYLAND
<b>12. CITIZEN OF WHAT COUNTRY?</b> USA		<b>13. FATHER'S NAME</b> CONRAD MECKEL	
<b>14. MOTHER'S MAIDEN NAME</b> (HUEMMER) ELIZABETH		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) NO	
<b>16. SOCIAL SECURITY NO.</b> 214206028		<b>17. INFORMANT</b> RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL-WILKENS & CATON AVE	
<b>18. CAUSE OF DEATH</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
<b>19A. DATE OF OPERATION</b> 12/29/70		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> Acute Posterior MI	
<b>20A. AUTOPSY?</b> (Yes or No) NO		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> YES	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) ST AGNES HOSPITAL	
<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)	
<b>21E. INJURY OCCURRED</b> White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> DECEMBER 28, 1970 <b>to</b> DECEMBER 29, 1970 <b>and that (I) (we) last saw the deceased alive on</b> DECEMBER 29, 1970 <b>and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above.</b> (X) (We) (did) (not) view the body after death.			
<b>23A. SIGNATURE</b> Ching-Hui Tsai, M.D.		<b>23B. DATE SIGNED</b> 12/29/70	
<b>23C. PHYSICIAN'S NAME (Type)</b> Ching-Hui Tsai, M.D.		<b>23D. ADDRESS</b> BALTIMORE MD 21229 ST AGNES HSP WILKENS & CATON AVE	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> Burial	<b>24B. DATE</b> 1 2 71	<b>24C. NAME OF CEMETERY OR CREMATORY</b> Holy Cross	<b>24D. LOCATION</b> (City, town, or county) (State) Balto. Md.
<b>25A. DATE REC'D BY HEALTH DEPT.</b> JAN 4 1971		<b>25B. NAME OF REGISTRAR</b> Robert E. Taber, M.D.	
<b>25C. FUNERAL DIRECTOR</b> Mc Cully		<b>ADDRESS</b> 130 E. Fort Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-200		70 12750		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12750	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>HAASE, IDA L.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Union Memorial Hospital</b>				2. DATE AND HOUR OF DEATH <b>12/29/70 3:15 A.M.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>2904 Southern Avenue 2733</b>			
5. SEX <b>Female</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>03-02-86</b>	9. AGE (in years last birthday) <b>84</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Wise Bros.</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>American</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY <b>Seamstress</b>			
13. FATHER'S NAME <b>Herman Haase</b>				14. MOTHER'S MAIDEN NAME <b>ANNA PLAGGEMEYER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>215-05-9259A</b>		17. INFORMANT <b>CHART</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arterio sclerotic heart disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <b>Cerebro vascular accident</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12/27</b> 19 <b>70</b> to <b>12/29</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>12/28</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>S. Cheikh</b>				23B. DATE SIGNED <b>12/29/70</b>		23C. PHYSICIAN'S NAME (Type) <b>ISSAM E. CHEIKH</b>	
23D. ADDRESS <b>Union Memorial Hospital</b>				23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-2-71</b>		24C. NAME of CEMETERY or CREMATORY <b>Prospect Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>York Road Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Pabst</b>		25C. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b>		25D. ADDRESS <b>7101 Belair Rd. 21236</b>	



## FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
Y-362		70 12751		70 12751	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Peterson, Henry W.			12-28-70 4:15 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Baltimore City Hospitals 4940 Eastern Avenue Balt. City Hospital, Eastern Ave			Md. Baltimore		
5. SEX			6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male			White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH
Farmer			Farming		2-22-04
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)
Paul Peterson			Polly Davis		66
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)
No			237-16-0398		North Carolina
17. INFORMANT			ADDRESS		12. CITIZEN OF WHAT COUNTRY?
BCH Records: Baltimore, Md. 21224			4940 Eastern Avenue		U.S.A.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		4 days
ANTECEDENT CAUSES			(B) Carcinoma of rectum		1 yr
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
12-27-70		12-27-70		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 12-26-70 to 12-28-70 that (I) (we) lost saw the deceased alive on 12-29-70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Ronald Blum md				12-28-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Ronald Blum md				4940 Baltimore City Hospitals Eastern Ave	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Removal		12/29/70		Lodford Funeral Home	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 4 1971		Robert E. Taylor, M.D.		Bruzdzinski Funeral Home	
				ADDRESS	
				1407 Eastern Ave.	

1951-52

1951-52

1951-52

1951-52

1951-52

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12752		BALTIMORE CITY HEALTH DEPARTMENT		70 12752	
BIRTH NO. <span style="font-size: 2em;">K-400</span>		70 12752		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		EDNA B. KEIL		2. DATE AND HOUR OF DEATH December 29, 1970	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION  2614 St. Benedict Street Baltimore, Maryland		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Retail Credit Bureau		8. DATE OF BIRTH 12-23-1905	
13. FATHER'S NAME Louis Heintz		14. MOTHER'S MAIDEN NAME Caroline Appel		9. AGE (in years last birthday) 65	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-22-7279		11. BIRTHPLACE (State or foreign country) Maryland	
17. INFORMANT Mr. George Sempeles, 501 Keyser Bldg. 21202		ADDRESS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic cardiovascular disease</i> (B) <i>Generalized Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Bronch. Asthma</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 yrs</i>	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II		19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month ( ) Day ( ) Year ( ) Hour ( )		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>March 1964</i> to <i>1970</i> that (I) (we) last saw the deceased alive on <i>Sept 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Justin Kudirka</i>		23B. DATE SIGNED 12/30/70		23C. PHYSICIAN'S NAME (Type) Justin Kudirka	
23D. ADDRESS 2151 Wilkens Avenue, Baltimore, Md.		23E. DEGREE DEGREE		23F. ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-2-1971		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. JAN 4 1971		24F. NAME OF REGISTRAR <i>Robert E. Vandy, Jr.</i>	
24G. NAME OF REGISTRAR		24H. NAME OF REGISTRAR		24I. NAME OF REGISTRAR	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>70 12753</b>	
<b>BIRTH NO.</b> <b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>Louis B. Glick</b>		<b>70 12753 CERTIFICATE OF DEATH</b>			
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Maryland General Hospital</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>12/27/70 7:00 A.M.</b>			
<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		<b>5. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
<b>6. STREET ADDRESS</b> (If rural, give location) <b>6229 Berkeley Ave. 2730</b>		<b>7. SEX</b> <b>M</b>			
<b>8. RACE</b> <b>W</b>		<b>9. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (specify) <b>Married</b>		<b>10. DATE OF BIRTH</b> <b>7/3/1922</b>	
<b>11. AGE</b> (In years last birthday) <b>48</b>		<b>12. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>13. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>14. FATHER'S NAME</b> <b>Benjamin</b>		<b>15. MOTHER'S MAIDEN NAME</b> <b>Bessie</b>		<b>16. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
<b>17. SOCIAL SECURITY NO.</b> <b>217-05-6998-A</b>		<b>18. INFORMANT</b> <b>Sadye Glick 6229 Berkeley Ave</b>			
<b>19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) <b>410.9 I</b> <b>Pulmonary congestion</b>		<b>20. CAUSE OF DEATH</b> <b>Myocardial infarction</b>		<b>21. INTERVAL BETWEEN ONSET AND DEATH</b> <b>a month</b>	
<b>22. ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>		<b>23. DUE TO</b> <b>(A) Myocardial infarction</b> <b>(B) Myocardial infarction</b> <b>(C) ASCVD</b>			
<b>24. DATE OF OPERATION</b> <b>2</b>		<b>25. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>26. AUTOPSY?</b> (Yes or No) <b>Yes</b>	
<b>27. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <b>yes</b>					
<b>28. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>29. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>30. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>31. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>32. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>33. HOW DID INJURY OCCUR?</b>	
<b>34. I certify that (I) (this hospital) attended the deceased from</b> <b>Nov 25 1970</b> <b>to</b> <b>Dec 27 1970</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>Dec 27 1970</b> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour</b> <b>and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>35. SIGNATURE</b> <b>R. Tsukamoto</b> M.D.				<b>36. DATE SIGNED</b> <b>12/27/70</b>	
<b>37. PHYSICIAN'S NAME</b> (Type) <b>R. Tsukamoto</b> M.D.				<b>38. ADDRESS</b> <b>Maryland General Hospital</b>	
<b>39. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>40. DATE</b> <b>12/28/70</b>		<b>41. NAME OF CEMETERY or CREMATORY</b> <b>Chapel Ameno</b>	
<b>42. LOCATION</b> (City, town, or county) <b>Bolton</b>		<b>43. STATE</b> <b>MD</b>			
<b>44. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 4 1971</b>		<b>45. NAME OF REGISTRAR</b> <b>Robert E. Taylor</b>		<b>46. FUNERAL DIRECTOR</b> <b>Sylvan Lewis &amp; Son 9610 Reisterstown Rd</b>	

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BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 12754

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Herbert T. Snodgrass, Sr.				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 12 29 70 6:25 a M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2159 Whistler Ave.				3. DATE PRONOUNCED DEAD Month Day Year Hour 12 29 70 6:25 a M.			
FULL NAME OF HOSPITAL OR INSTITUTION				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
6. SEX male	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH March 30, 1910		10. AGE (In years last birthday) 60		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick H. Snodgrass		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		15. MOTHER'S MAIDEN NAME Ellie Collier		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 11	
17. SOCIAL SECURITY NO. 229 12 5857		18. INFORMANT Mrs. A.R. Applegate (daughter)		ADDRESS Kingsport Tenn.		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fatty alteration of liver DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/29/70							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan. 2/71		24C. NAME OF CEMETERY or CREMATORY Oak Hill Cemetery		24D. LOCATION (City, town, or county) (State) Kingsport, Tenn.	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1971		25B. NAME OF REGISTRAR Robert E. Spitz		25C. FUNERAL DIRECTOR Singleton Funeral Home		ADDRESS Glen Burnie, Md.	

MSI 07

MSI 07

X

*Handwritten signature*

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

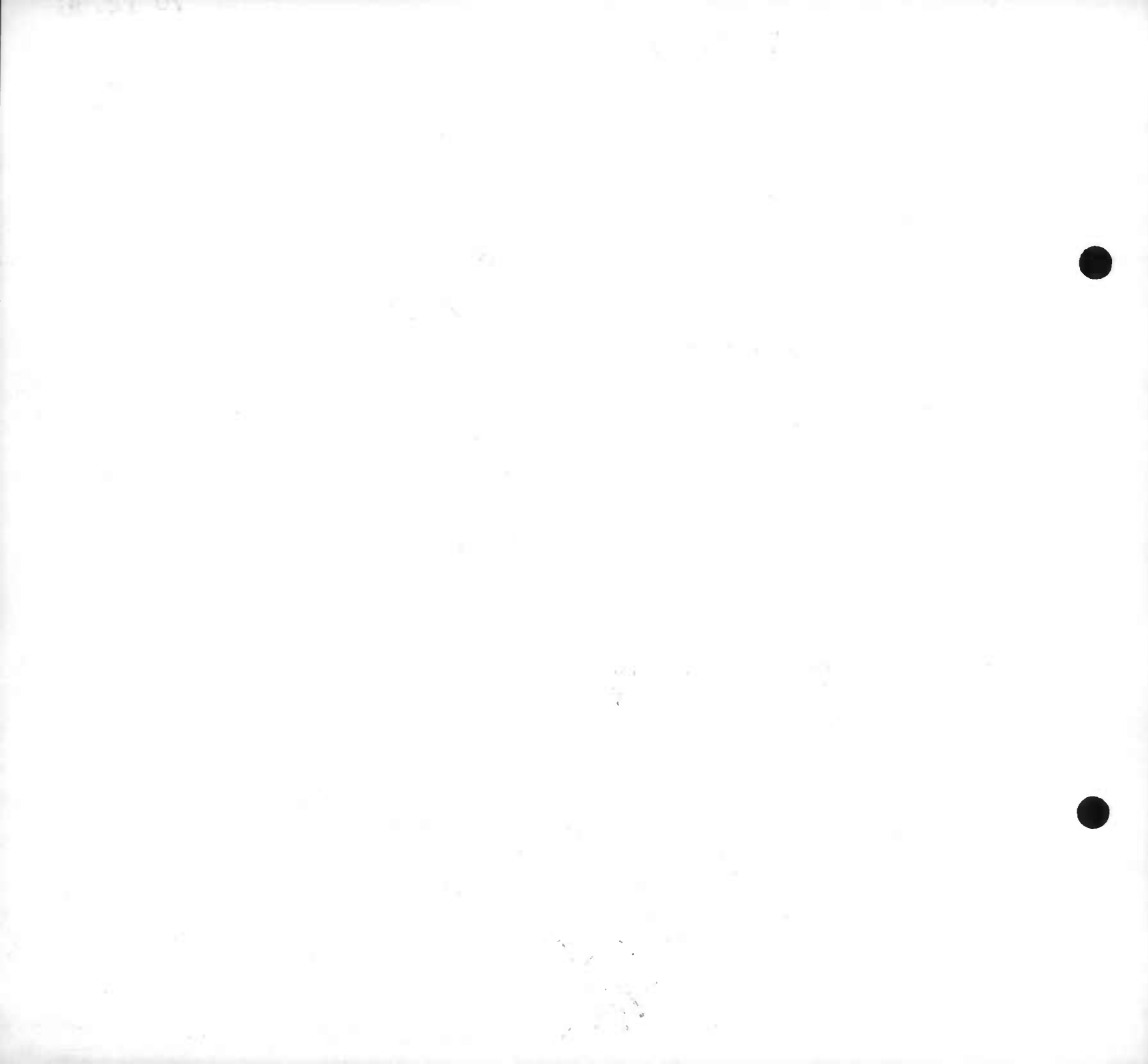
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12755	
BIRTH NO. <u>B-520</u>		70 12755		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>VIRGINIA BANKS</u>			2. DATE AND HOUR OF DEATH <u>DEC. 29 - 1970 1025A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 N. MORLEY ST</u>			A. STATE <u>MD</u> B. COUNTY <u>MD</u>		
			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>44 N. MORLEY ST 2047</u>		
5. SEX <u>FE.</u>	6. RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 11, 1890</u>		9. AGE (In years last birthday) <u>80</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>	
13. FATHER'S NAME <u>WILLIAM F. BURNETT</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>EDITH EDWARDS 44 N. MORLEY ST</u>
18. <u>43691</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Probable Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerotic Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>many years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>August 1</u> 19 <u>70</u> to <u>December 19</u> 19 <u>70</u> that (I) ( <del>we</del> ) lost saw the deceased alive on <u>December 14</u> 19 <u>70</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death.					
23A. SIGNATURE <u>Robert A. Adler M.D.</u>				23B. DATE SIGNED <u>12/29/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert A. Adler M.D.</u>				23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>1/2/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Oak Grove Baptist</u>	
24D. LOCATION (City, town, or county) (State) <u>Essex Co VA</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 4 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, Jr.</u>		25C. FUNERAL DIRECTOR <u>Donna H. Hays 638 N. GLENN ST</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 12756		70 12756	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>MADYLING JENINSON</b>				2. DATE AND HOUR OF DEATH <b>DEC. 30-1970 130 P M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>655 W. FRANKLIN ST</b>				A. STATE <b>MD</b>		B. COUNTY	
				C. CITY OR TOWN <b>BALTO CITY</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>655 W. FRANKLIN ST 1701</b>			
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 27-09 61</b>	9. AGE (in years last birthday) <b>61</b>	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>		
13. FATHER'S NAME <b>BUD JENINSON</b>				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Isaac Blake</b>		
					ADDRESS <b>3008 AUCHENTOROUGH T</b>		
18. <b>412.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>A.S.C.V.D. a few years</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				(B) <b>Hypertension, Benign</b>			
				(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>11-5-1969</b> to <b>12-30-1970</b> that (1) (we) last saw the deceased alive on <b>12-30-1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>H. Nakazawa</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12-31-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>H. NAKAZAWA</b>				23D. ADDRESS <b>521 W. Lexington St. Balto Md 21201</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1/7/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MT CARMEL</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO MD 21225</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>William A. Hays</b>		ADDRESS <b>6384 Guilford Rd</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

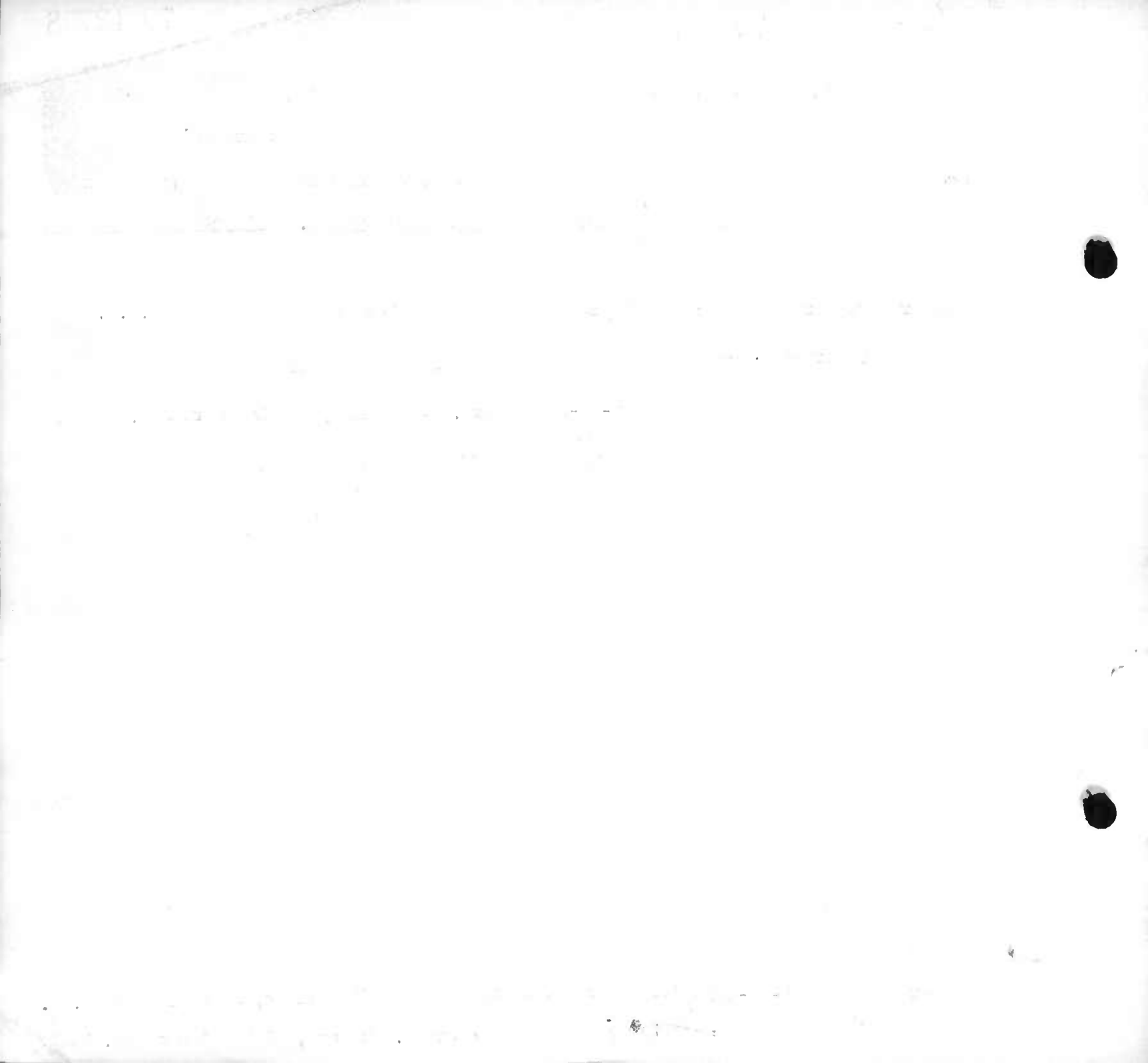
<p><b>K-613</b>      <b>70 12757</b></p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p> <p style="text-align: right;">REG. NO. <b>70 12757</b></p>					
<p>BIRTH NO. _____</p>		<p>1. NAME OF DECEASED (Type or Print) <b>OWEN KRAFT</b></p>		<p>2. DATE AND HOUR OF DEATH <b>12/29/70 7:30 A.M.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>Sinai Hosp</b></p>			<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Bolte</b></p>		
<p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Sinai Hosp</b></p>			<p>C. CITY OR TOWN <b>Pikesville</b></p>		<p>D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>
<p>5. SEX <b>M</b> 6. RACE <b>W</b></p>			<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <b>12/25/1907</b> 9. AGE (in years last birthday) <b>63</b></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b></p>			<p>10B. KIND OF BUSINESS OR INDUSTRY _____</p>		<p>11. BIRTHPLACE (State or foreign country) <b>Poland</b></p>
<p>12. CITIZEN OF WHAT COUNTRY? <b>USA</b></p>			<p>13. FATHER'S NAME <b>Abraham</b></p>		
<p>14. MOTHER'S MAIDEN NAME <b>Sarah</b></p>			<p>15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b></p>		
<p>16. SOCIAL SECURITY NO. <b>215-094623</b></p>			<p>17. INFORMANT <b>Hop chad</b> ADDRESS _____</p>		
<p>18. <b>410.91</b> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF: <b>days</b></p> <p>(B) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF: <b>year 1</b></p> <p>(C) _____</p>					
<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____</p>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION _____</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____</p>		<p>20A. AUTOPSY? (Yes or No) <b>No</b></p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____</p>		<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)</p>			
<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____</p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____</p>		<p>21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work</p>		<p>21F. HOW DID INJURY OCCUR? _____</p>	
<p>22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/28</b> 19 <b>70</b> to <b>12/29</b> 19 <b>70</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/29</b> 19 <b>70</b> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <b>Barbado, M.D.</b></p>				<p>23B. DATE SIGNED <b>12/29/70</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>BARBADO M.D.</b></p>				<p>23D. ADDRESS <b>Sinai Hosp. of Baltimore</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>12/31/70</b></p>		<p>24C. NAME of CEMETERY or CREMATORY <b>Beth Sholom</b></p>	
<p>24D. LOCATION (City, town, or county) <b>Bolte</b></p>		<p>24E. STATE <b>MD</b></p>			
<p>25A. DATE RECD BY HEALTH DEPT. <b>JAN 4 1971</b></p>		<p>25B. NAME OF REGISTRAR <b>John J. ...</b></p>		<p>25C. FUNERAL DIRECTOR <b>Sylvan ...</b> ADDRESS <b>509 9610 ...</b></p>	

45/51

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

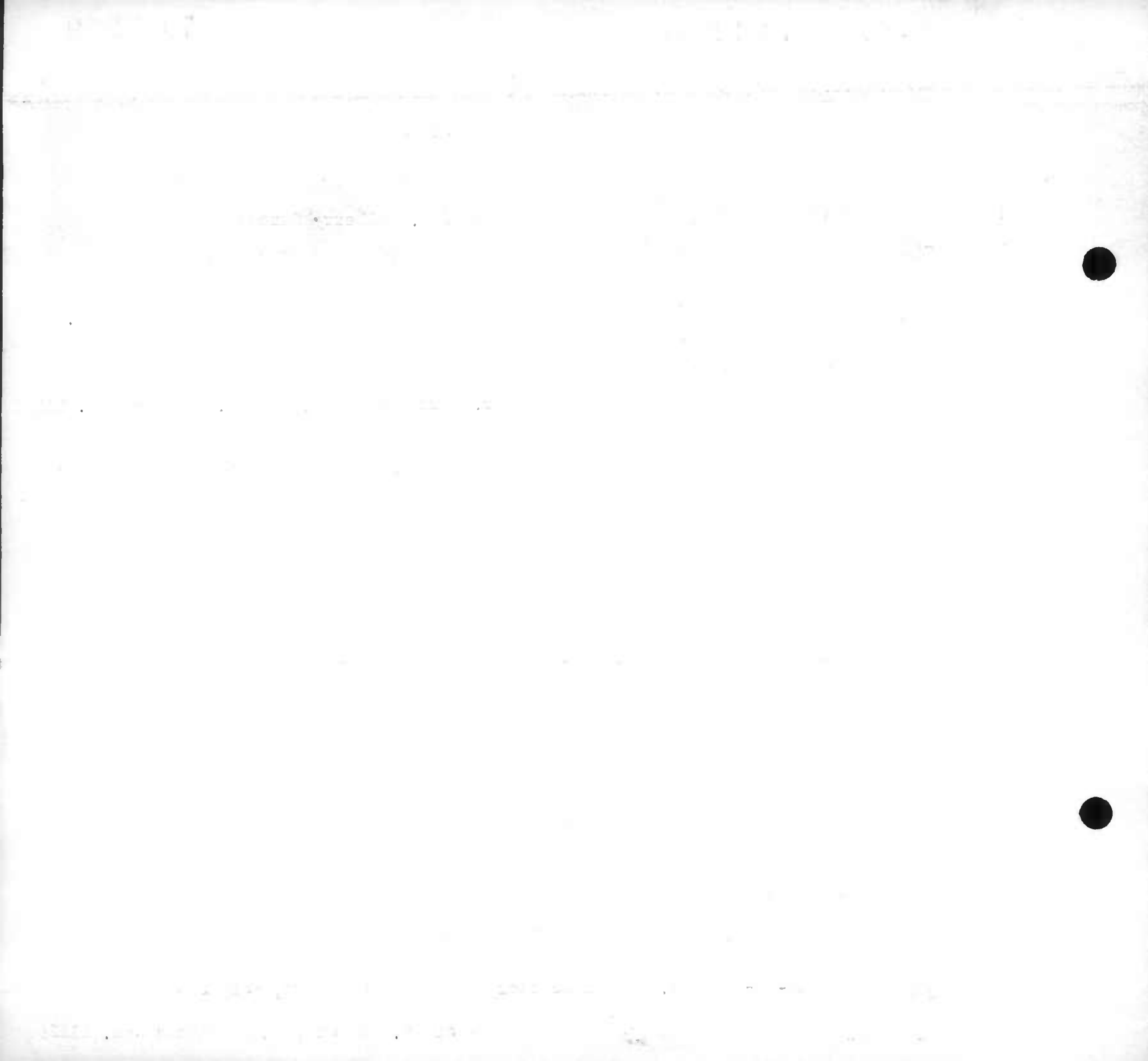
1-520		70 12758		BALTIMORE CITY HEALTH DEPARTMENT		70 12758	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Lins, William F. Sr.				Dec 28th, 1970 9:10 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Saint Agnes Hospital Caton & Wilkens Aves. 21229				Maryland Anne Arundel			
5. SEX				6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
m				white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Retired Grocer				Self Employed		9/21/94	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
Frederick W. Lins				Annie Sommers		76	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)	
No				212-10-7537		Maryland	
17. INFORMANT				12. CITIZEN OF WHAT COUNTRY?			
Mrs. Naomi Lins, 506 LaClaire Ave. 21090				U.S.A.			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Chronic Myocardial Failure			
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Ventricular Arrhythmia			
(C)				< 1 hr			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from 19 97 to Dec 19 70 that (1) (we) last saw the deceased alive on Dec 10 19 70 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Raymond Bahr MD							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Raymond Bahr MD							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12-31-1970		Glen Haven Cemetery		Glen Burnie, Anne Arundel Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 4 1971		Robert E. Taylor, MD		Howard H. Hubbard, 4107 Wilkens Ave. 21229			



# FUNERAL DIRECTOR: IMPORTANT

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P-420 70 12759		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12759	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mrs. Bertha L. Pollock</i>		2. DATE AND HOUR OF DEATH <i>12-28-70 6:35 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hosp. Balt. &amp; Pulaski</i>		C. CITY OR TOWN <i>Balt. Ind.</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>3-3-86</i>		9. AGE (In years last birthday) <i>84</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Rosenthal</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-24-4382</i>	
17. INFORMANT <i>Mr. Morris Pollock</i>		ADDRESS <i>1945 W. Mulberry St. 21223</i>		18. CAUSE OF DEATH <i>Bilateral CVA.</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Bilateral CVA</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Bilateral CVA</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>13 wks.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i>		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>12-21-70</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>NO</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12-21</i> 19 <i>70</i> to <i>12-28</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>12-28</i> 19 <i>70</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jantira Voraraksa MD</i>		23B. DATE SIGNED <i>12-28-70</i>		23C. PHYSICIAN'S NAME (Type) <i>JANTIRA VORARAKSA MD</i>	
23D. ADDRESS <i>B.S.H.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-31-70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 4 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Huber</i>		25C. FUNERAL DIRECTOR <i>Howard H. Hubbard</i>	
ADDRESS <i>4107 Wilkens Ave. 21229</i>					



# FUNERAL DIRECTOR: IMPORTANT

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G-600		70 12760		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 12760	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>MRS. Katherine Grewe</i>			
2. DATE AND HOUR OF DEATH <i>December 27, 1970 8:00 p.m.</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Bon Secours Hosp.</i>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <i>714 Woodsdale Rd. 5300</i>	
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/9/95</i>	9. AGE (in years last birthday) <i>75 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <i>United States</i>		13. FATHER'S NAME <i>William Reed</i>	
14. MOTHER'S MAIDEN NAME <i>Gussie ?</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-09-9284</i>		17. INFORMANT ADDRESS <i>Mr. William Grewe, 714 Woodsdale Road 21228</i>	
18. <i>473X</i> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pulmonary embolus, left lower lobe branch, left pulmonary</i>		<i>days</i>	
				(B) <i>Bronchopneumonia, left lower lobe</i>		<i>weeks</i>	
				(C) <i>Bronchial asthma</i>		<i>year</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>2/27</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12-27-70</i> 19 <i>70</i> to <i>12-27</i> 19 <i>70</i> and that (I) (we) last saw the deceased alive on <i>12-27</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Janira Voraraksa</i>				23B. DATE SIGNED <i>12-27-70</i>		23C. PHYSICIAN'S NAME (Type) <i>JANIRA VORARAKSA</i>	
23D. ADDRESS <i>Bon Secours Hospital</i>				23E. PHYSICIAN'S NAME (Type) <i>Robert E. Taylor, M.D.</i>		23F. PHYSICIAN'S ADDRESS <i>Howard H. Hubbard, 4107 Wilkens Ave. 21229</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-31-70</i>		24C. NAME of CEMETERY or CREMATORY <i>Lorraine Park Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Woodlawn, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 4 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Howard H. Hubbard</i>		25D. ADDRESS <i>4107 Wilkens Ave. 21229</i>	



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BIRTH NO. <span style="float: right;">70 12761</span>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">70 12761</span>	
1. NAME OF DECEASED (Type or Print) <b>DR. L. REX SPRINGER</b>			2. DATE AND HOUR OF DEATH <b>December 26, 1970</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>St. Agnes Hospital Caton &amp; Wilkens Avenues</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____ C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1718 De Soto Road</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-15-1902</b>	9. AGE (in years last birthday) <b>68</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pharmacist</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Lewis R. Springer</b>		
14. MOTHER'S MAIDEN NAME <b>Lena E. Adams</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>214-26-0519</b>			17. INFORMANT <b>Mrs. Bonnita E. Topolski, 8211 Arrowhead Rd.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>410.9 I Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Coronary Arteriosclerosis</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/23</b> 19 <b>70</b> to <b>12/26</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>12/23</b> 19 <b>70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John C. Healy</b>				23B. DATE SIGNED <b>12/28/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>John C. Healy</b>				23D. ADDRESS <b>1311 Francis Avenue, Baltimore, Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-30-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Meadow ridge Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Washington Blvd. Howard Co., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1971</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave, 21229</b>			

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12762	
BIRTH NO. M-620		70 12762		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MR. JOHN MORRIS		John W. Morris, Sr.		2. DATE AND HOUR OF DEATH Dec. 29, 1970	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL		A. STATE MARYLAND		B. COUNTY Baltimore	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION BALTIMORE, MARYLAND 21231		C. CITY OR TOWN Edgemere		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2310 LODGE FARM ROAD		5300	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/13	9. AGE (in years last birthday) 57	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME Seibert Morris		14. MOTHER'S MAIDEN NAME CLEMMONT KNIGHT		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-5628		17. INFIRMANT (WIFE) MARGUERITE MORRIS ADDRESS SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: SEVERE APLASTIC ANEMIA			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) THROMBASTHENIA, HEMORRHAGIC GASTRITIS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 12/8 1970 to 12/29 1970 that (I) (we) last saw the deceased alive on 12/29 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A.C. Chouvalit, M.D.		23B. DATE SIGNED 12/29/70			
23C. PHYSICIAN'S NAME (Type) A.C. CHOUVALIT, M.D.		23D. ADDRESS CHURCH HOME & HOSPITAL BALTIMORE, MD. 21231			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-2-71		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
				24D. LOCATION Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1971		25B. NAME OF REGISTRAR Robert E. Bailey		25C. FUNERAL DIRECTOR John J. Duda	
				ADDRESS 7922 Wise Ave. Dundalk, Md.	

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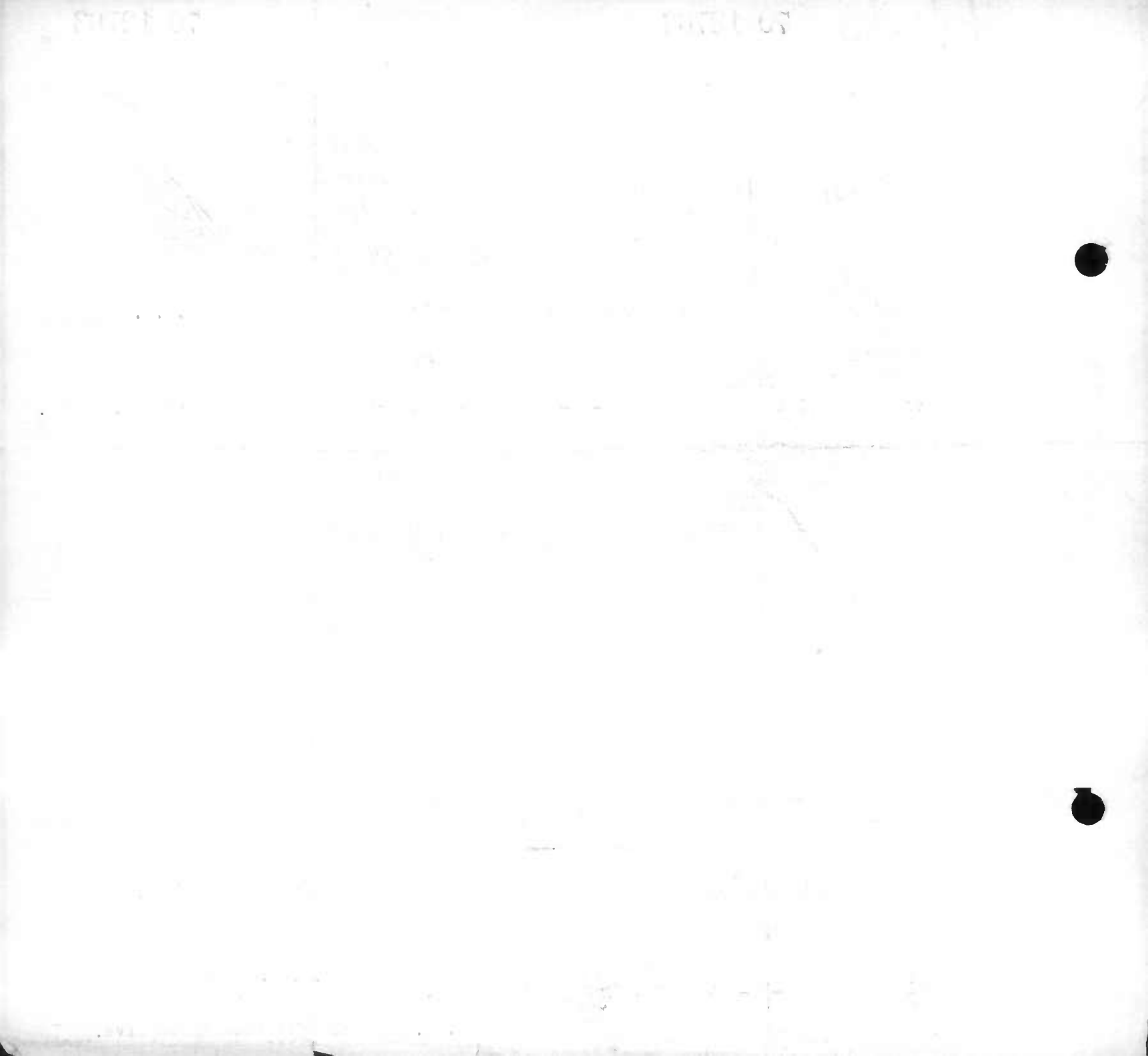
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12763</u>	
CERTIFICATE OF DEATH					
BIRTH NO. <u>W-300</u>		70 12763			
1. NAME OF DECEASED (Type or Print) <u>Lou Wood</u>			2. DATE AND HOUR OF DEATH <u>12-26-70</u> <u>3:30</u> a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3514 Hayward Ave.</u> <u>2788</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-13-98</u>	9. AGE in years last birthday <u>72</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home Improvement</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <u>WWIDno</u>		16. SOCIAL SECURITY NO. <u>705-05-2083</u>		17. INFORMANT ADDRESS <u>Mary Catherine Wood 3514 Hayward Av. Balto.</u>	
18. <u>736017-1621</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>CUA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>HYPER TENSION</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Ca of LUNG</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>12-26-</u> 19 <u>70</u> to <u>12-26</u> 19 <u>70</u> that (I) ( <del>we</del> ) last saw the deceased alive on <u>12-26</u> 19 <u>70</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death.					
23A. SIGNATURE <u>Ralph Epstein</u>			23B. DATE SIGNED <u>12-26-70</u>		23C. PHYSICIAN NAME (Type) <u>Ralph Epstein</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>12-31-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven Memorial Park</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 4 1971</u>			25B. NAME OF REGISTRAR <u>Wm. E. Johnson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>8521 Loch Raven Blvd. Baltimore, Maryland 21204</u>



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 12764

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

PEARL K FATZEN

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

3201 Arydale Avenue

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

December 30, 1970

11:58 A.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

6. SEX

Female

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

4/10/1896

10. AGE (In years  
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

3201 Arydale Avenue

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Hyman

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14b. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Bessie

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Mr. David Feldman Herndon, Va

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no (Inquiry)

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK ☐ AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☒ Inspection ☐ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/30/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12/31/70

24C. NAME of CEMETERY or CREMATORY

Har Zion

24D. LOCATION (City, town, or county)

Baltimore

(State)

MD

25A. DATE REC'D BY HEALTH DEPT.

JAN 4 1971

25B. NAME OF REGISTRAR

R. N. Kornblum

25C. FUNERAL DIRECTOR

Sydney Weiss &amp; Son

ADDRESS

Garrison, MD

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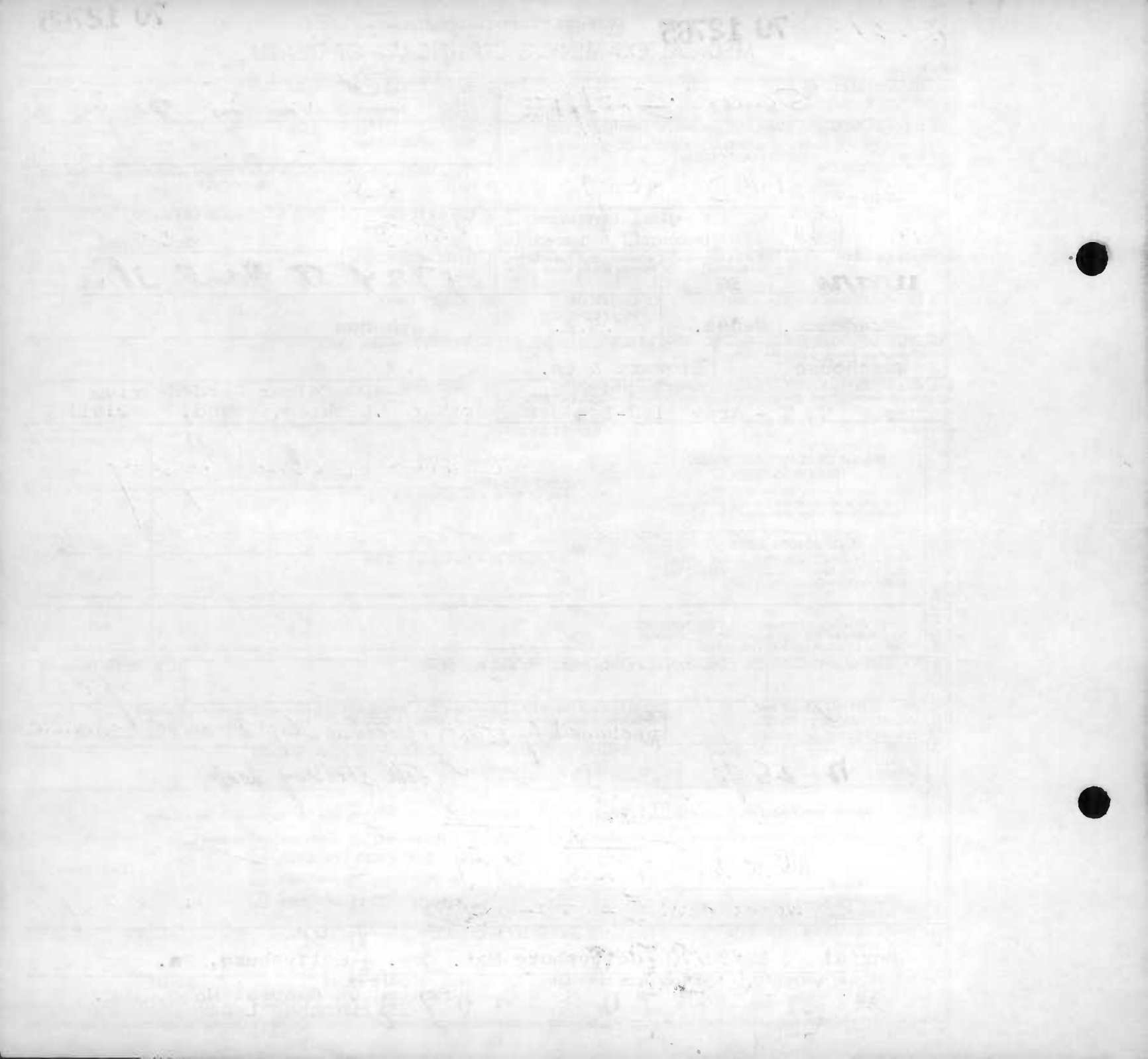
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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		70 12765	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Gomer L. Griffith</i>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12 25 70 4 <sup>25</sup> P.M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Univ. of MD Hosp.</i>		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 25 70 4 <sup>25</sup> P.M.		5. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>MD</i> B. COUNTY	
6. SEX <i>M</i>	7. RACE <i>W</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <i>Balto</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 11/17/14		10. AGE (In years last birthday) 56	11. BIRTHPLACE (State or foreign country) Braddock, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME unknown		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouse		15. MOTHER'S MAIDEN NAME "	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes WW 2 - Army		17. SOCIAL SECURITY NO. 182-14-6378		18. INFORMANT ADDRESS 4403 Colmar Garden Drive Arthur L. Lipkien, friend, 21211	
19. <i>E887X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cranio Cerebral Injury</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <i>2</i>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <i>yes</i>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) <i>presumably street</i>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <i>presumably E. North Avenue</i>	
22D. TIME OF INJURY (APPROX.) 12 25 70		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? <i>Fell striking head</i>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <i>Werner U. Spitz</i> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <i>Werner U. Spitz</i> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>12-26-70</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/30/70		24C. NAME OF CEMETERY or CREMATORY Gettysburg Nat. Cem.	
24D. LOCATION (City, town, or county) Gettysburg, Pa.		24E. NAME OF CEMETERY or CREMATORY Gettysburg Nat. Cem.		24F. LOCATION (City, town, or county) Gettysburg, Pa.	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1971		25B. NAME OF REGISTRAR <i>Robert E. H. H. H.</i>		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane	



58-18-01 djs

70 12766

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

70 12766

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Rosalie Deangelis

2. DATE AND HOUR OF DEATH

12/25/70

1 855 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1001 North Janney Street

21224

5. SEX

Female

6. RACE

White

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

8. DATE OF BIRTH

6-4-05

9. AGE (in years  
last birthday)

65

10. Under 1 Yr. 11. Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Assembly Line

10B. KIND OF BUSINESS OR INDUSTRY

Bendix Corp.

11. BIRTHPLACE (State or foreign country)

Maryland, Baltimore

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Robinson

14. MOTHER'S MAIDEN NAME

Sophia Ruppert

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

213-20-7716

17. INFORMANT

4940 Eastern Avenue ADDRESS  
Baltimore, Maryland 21224

BCH: Records

18. 486X I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Probable Sepsis

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

One day

(B) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Probable Pneumonia

One week

Saline depletion

3 months

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH? YES21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 12/25 1970 to 12/25 1970  
that (2) (we) last saw the deceased alive on 12/25 1970 and that in (3) (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Russell Harris M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

12/25/70

23C. PHYSICIAN'S  
NAME (Type)

Russell Harris M.D.

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12/29/70

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 4 1971

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

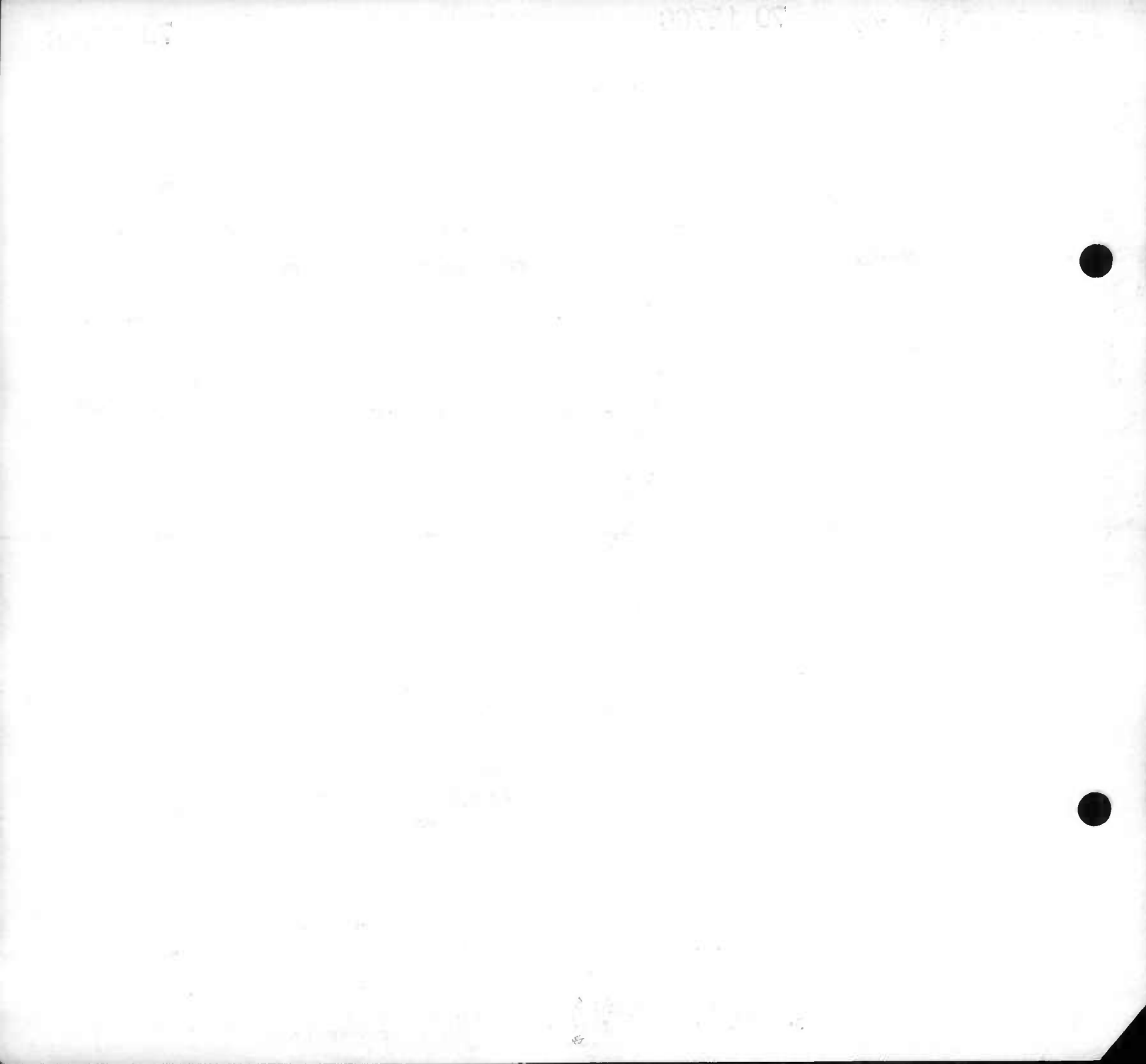
Schimunek Funeral Home, Inc.

3331 Brehms Lane

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released on Approval  
FUNERAL DIRECTOR: IMPORTANT

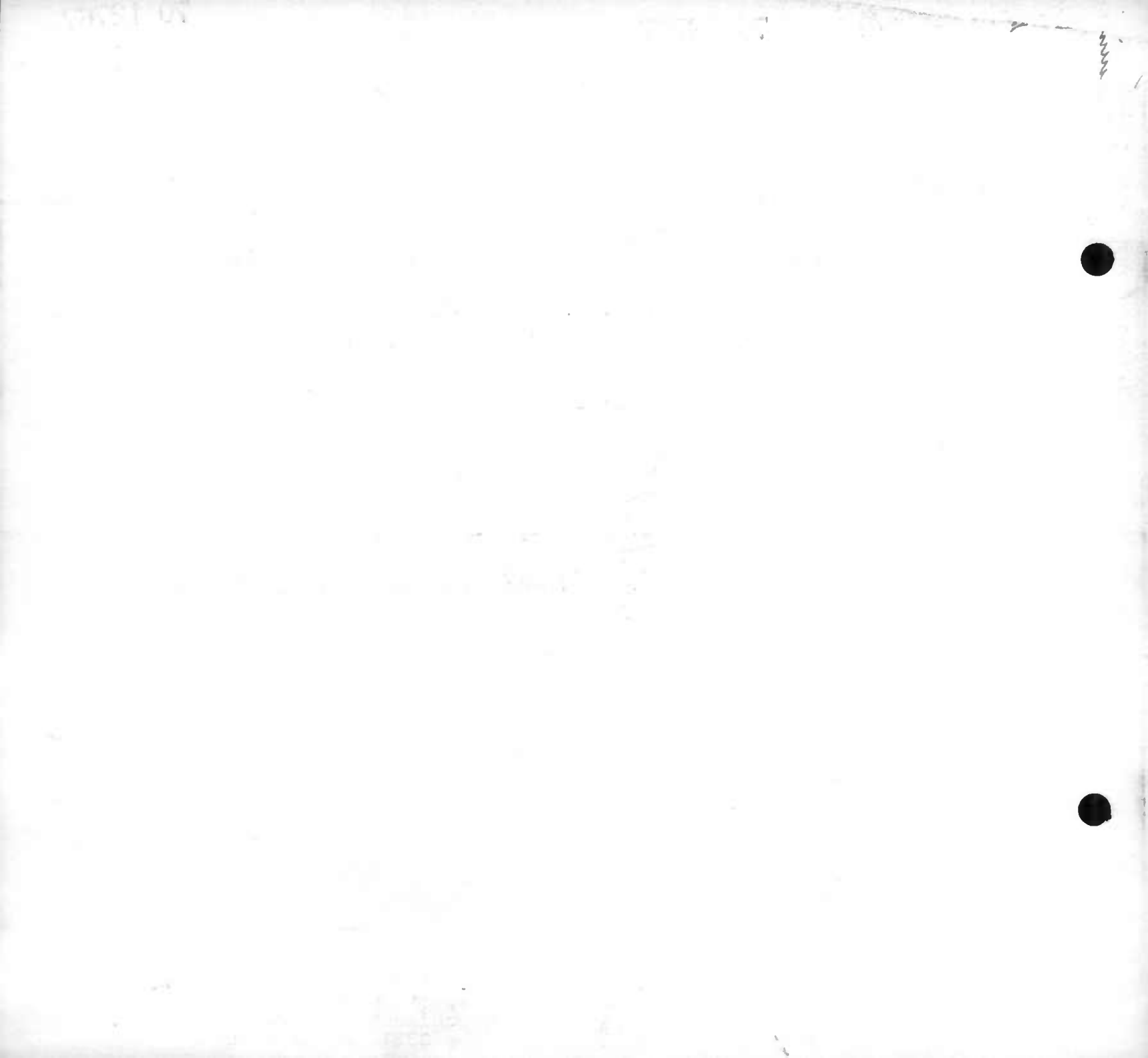


Released on approval of Med. Examiner.

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

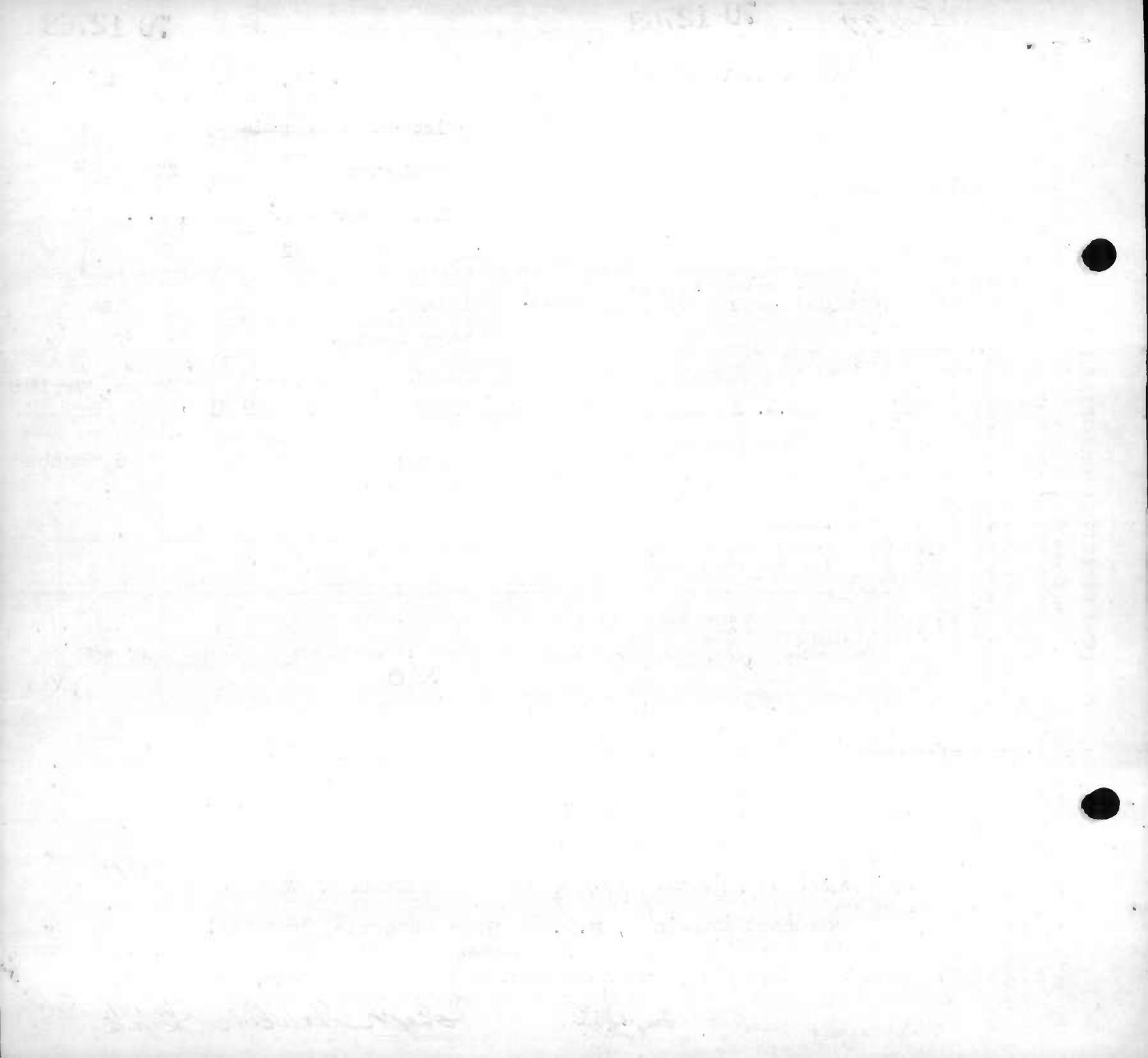
70 12767		BALTIMORE CITY HEALTH DEPARTMENT		70 12767	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
McCALL, WILLIAM A. (SR.)		29 Dec 70.		6.30 AM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
Union Memorial Hospital, Baltimore Md 21218. 33 rd and Calvert streets		Maryland.			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
male		white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired.		B & O R. R.		Maryland. Baltimore	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John McCall		Florence Weinkamp		American.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
		215-10-4598		medical records - Union Memorial Hospital	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
12-25-70 9:30 PM		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		fell down 5 stories	
22. I certify that (I) (this hospital) attended the deceased from 12-26-70 to 12-27-70 that (I) (we) last saw the deceased alive on 12-27-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE					
Fatih Salih Zada, M.D.					
23B. DATE SIGNED					
23C. PHYSICIAN'S NAME (Type)					
FATIH SALIH ZADA M.D.					
23D. ADDRESS					
Union Memorial Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify)					
Burial					
24B. DATE					
12/30/70					
24C. NAME OF CEMETERY OR CREMATORY					
Meadowridge Mem. Park					
24D. LOCATION (City, town, or county) (State)					
Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT.					
JAN 4 1971					
25B. NAME OF REGISTRAR					
Robert E. Taylor, M.D.					
25C. FUNERAL DIRECTOR					
Schimunek Funeral Home, Inc.					
3331 Brehms Lane					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

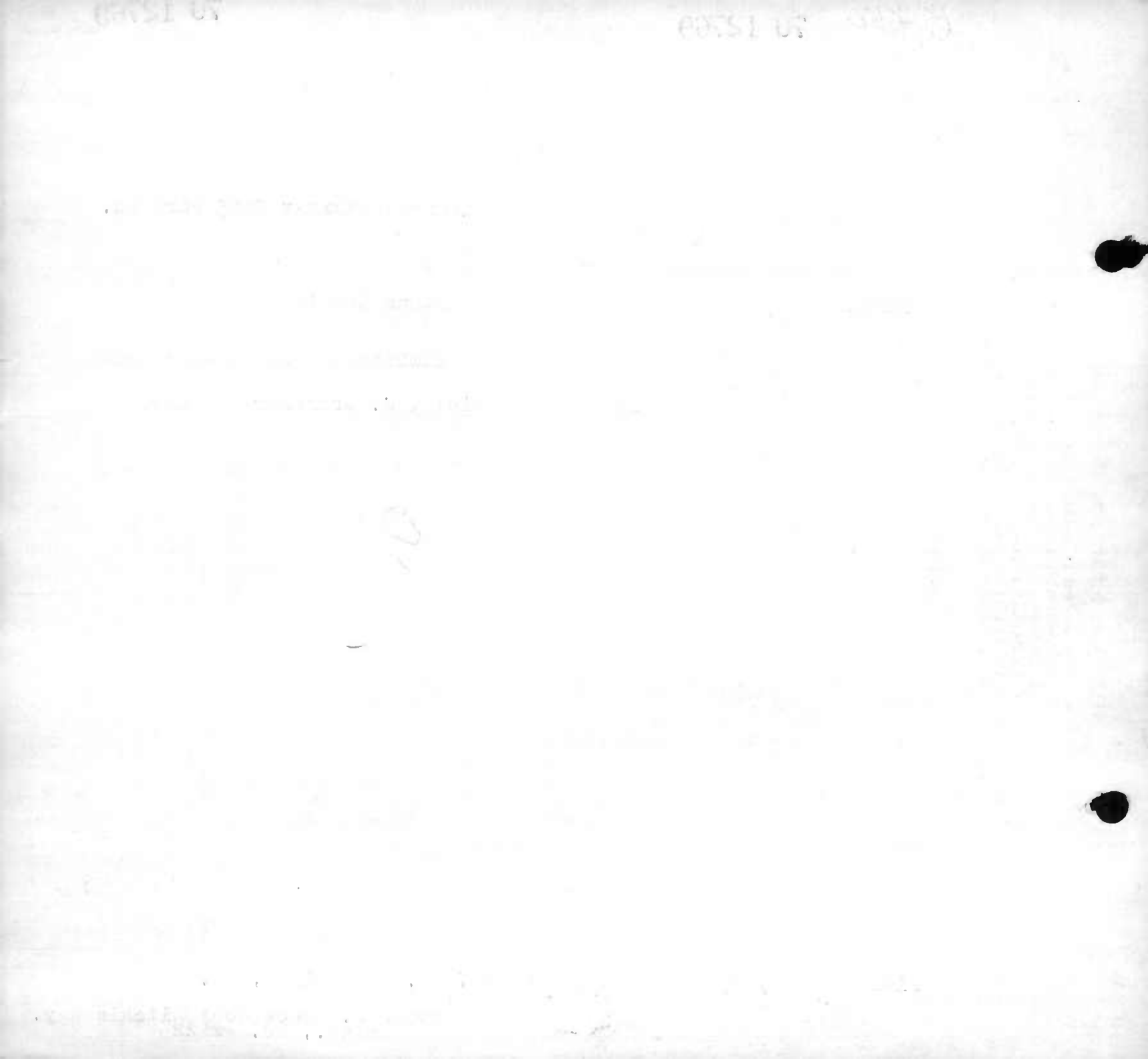
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12768	
<b>F-420</b> <b>70 12768</b> <b>CERTIFICATE OF DEATH</b>					
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>Elisha Noel Fales</b>				<b>2. DATE AND HOUR OF DEATH</b> <b>Dec. 22, 1970</b> <b>5:15 A.</b> M.	
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>Good Samaritan Hospital</b>				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>District of Columbia</b> B. COUNTY _____ <b>C. CITY OR TOWN</b> <b>Washington</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>2122 Massachusetts Avenue, N.W.</b>	
<b>5. SEX</b> <b>M</b>	<b>6. RACE</b> <b>Cau</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>12/23/87</b>	<b>9. AGE</b> years <b>82</b> (lost birth day)	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Aeronautical engr</b>
<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Federal Aviation Admin.</b>			<b>11. BIRTHPLACE</b> (State or foreign country) <b>Illinois</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>David Fales</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Lowgon</b>	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>W.W. I</b>		<b>16. SOCIAL SECURITY NO.</b> <b>228528939</b>	<b>17. INFORMANT</b> <b>Hospital chart and son, David Fales</b>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <b>Leukemia</b> <b>Acute Granulocytic</b> (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 months</b>	
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <b>No</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that</b> <input checked="" type="checkbox"/> <b>(this hospital) attended the deceased from</b> <b>11/4/70</b> <b>19</b> <b>to</b> <b>19</b> <b>that</b> <input checked="" type="checkbox"/> <b>(we) lost saw the deceased alive on</b> <b>12/22/70</b> <b>19</b> <b>and that</b> <input checked="" type="checkbox"/> <b>(our) opinion death occurred on the date</b> <b>and hour and from the causes stated above.</b> <input checked="" type="checkbox"/> <b>(We) (did) not view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>Michael Colvin, M.D.</b>				<b>23B. DATE SIGNED</b> <b>12/22/70</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>Michael Colvin, M.D.</b>				<b>23D. ADDRESS</b> <b>Good Samaritan Hospital</b>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24B. DATE</b> <b>12/28/70</b>	<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Pondville Cemetery</b>		<b>24D. LOCATION</b> (City, town, or county) <b>Urentham, Massachusetts</b>
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 4 1971</b>		<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Taylor</b>		<b>25C. FUNERAL DIRECTOR</b> <b>Joseph Fowler's Sons</b>	



# FUNERAL DIRECTOR: IMPORTANT

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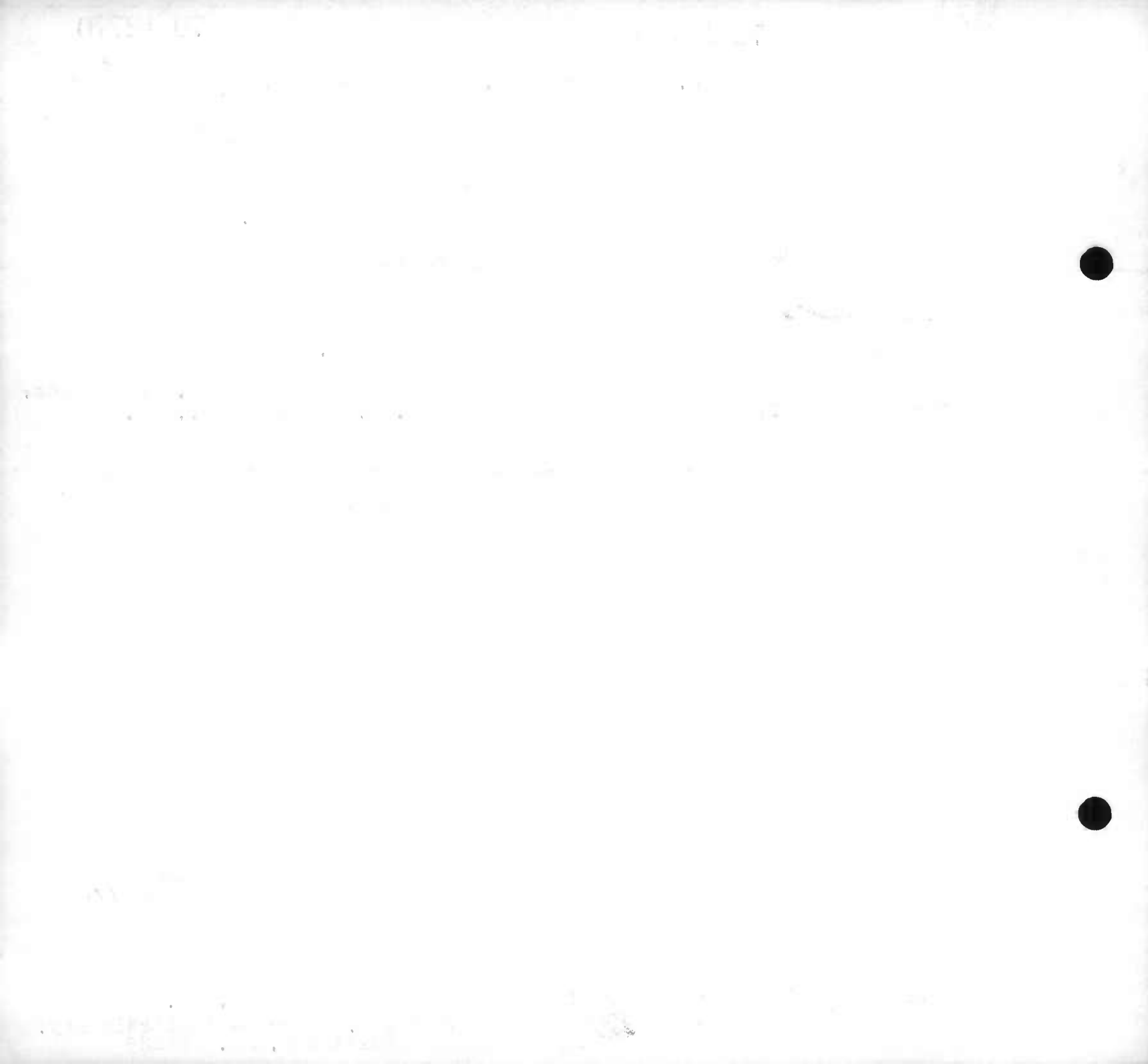
BALTIMORE CITY HEALTH DEPARTMENT				70 12769		Registered No. <span style="float: right;">70 12769</span>	
<b>BIRTH NO.</b> 650 <b>70 12769</b> <b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <i>Carol Judith Brown</i>				<b>2. DATE AND HOUR OF DEATH</b> <i>12/27/70</i> <i>10 P.M.</i>			
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <i>UNIVERSITY HOSP</i>				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <i>MD</i> <b>B. COUNTY</b> <i>AL</i> <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <i>Baltimore</i> <b>D. STREET ADDRESS</b> (If rural, give location) <i>5200 XXXXXXXXXXXXXXX 5605 Park Rd.</i>			
<b>5. SEX</b> <i>F</i>	<b>6. RACE</b> <i>W</i>	<b>7. MARRIED, NEVER MARRIED</b> <i>WIDOWED, DIVORCED (specify)</i> <i>separated</i>		<b>8. DATE OF BIRTH</b> <i>4/19/44</i>	<b>9. AGE</b> (In years lost birthday) <i>26</i>	<b>If Under 1 Yr.</b> Months: <i>0</i> Days: <i>0</i> Hours: <i>0</i> Min. <i>0</i> <b>If Under 24 Hrs.</b> Min. <i>0</i>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Waitress</i>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Pennsylvania</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>US</i>	
<b>13. FATHER'S NAME</b> <i>Milton Broseker</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>XXXXXXXX Violet Jane Cessna</i>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		<b>16. SOCIAL SECURITY NO.</b> <i>218 42 2119</i>		<b>17. INFORMANT</b> <i>Violet J. Broseker</i>		<b>ADDRESS</b> <i>Same</i>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<b>CAUSE OF DEATH</b> (A) <i>pulmonary embolus</i> DUE TO (B) <i>ulcerative colitis</i> DUE TO (C)		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>1 day</i> <i>years</i>	
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b> <i>renal failure, pneumonia</i>							
<b>19A. DATE OF OPERATION</b> <i>12/22</i>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <i>ischioanal abscess</i>		<b>20A. AUTOPSY?</b> (Yes or No) <i>yes</i>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <i>11/21</i> <b>19</b> <i>70</i> <b>to</b> <i>12/27</i> <b>19</b> <i>70</i> , <b>that (I) (we) last saw the deceased alive on</b> <i>12/22</i> <b>19</b> <i>70</i> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>							
<b>23A. SIGNATURE</b> <i>John A. Singer</i> <b>M.D.</b>						<b>23B. DATE SIGNED</b> <i>12-27-70</i>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <i>SINGER</i> <b>M.D.</b>				<b>23D. ADDRESS</b> <i>University Hosp.</i>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <i>Burial</i>		<b>24B. DATE</b> <i>12/31/70</i>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <i>Meadowridge Mem. Pk.</i>		<b>24D. LOCATION</b> (City, town, or county) (State) <i>Elkridge, Md.</i>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <i>JAN 4 1971</i>		<b>25B. NAME OF REGISTRAR</b> <i>Kabue E. Taylor, MD.</i>		<b>25C. FUNERAL DIRECTOR</b> <i>George J. Gonce</i>		<b>ADDRESS</b> <i>4001 Ritchie Hgy. Balto., Md. 21225</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12770	
70 12770		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>JOHN J. RECKER Jr.</b>		2. DATE AND HOUR OF DEATH <b>12/28/70 1:45 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>49 North Charles Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Anne Arundel</b>	
5. SEX <b>M</b> 6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <b>1-5-06</b>		9. AGE (in years last birthday) <b>64</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boiler Supply</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John J. Recker</b>		14. MOTHER'S MAIDEN NAME <b>Anne E. Hill</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>213-05-6205</b>	
17. INFORMANT <b>500 Md. Trust Bldg. 205 Geo. W. Della Balto., Md.</b>		18. CAUSE OF DEATH	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic cancer, generalized</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>under 1 yr.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Lung cancer</b>		over 1 year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Congestive heart failure</b>			
19A. DATE OF OPERATION <b>0 -</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) 1 (Month) 1 (Day) 1 (Year) 1 (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>12/26/70</b> 19 to <b>12/28/70</b> 19 that (X) (we) last saw the deceased alive on <b>12/28/70</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Jorge A. Bello MD</b>		23B. DATE SIGNED <b>12/28/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jorge A. Bello</b>		23D. ADDRESS <b>North Charles Gen. Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/31/70</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1971</b>		25B. NAME OF REGISTRAR <b>George J. Gonce</b>	
25C. FUNERAL DIRECTOR <b>George J. Gonce</b>		ADDRESS <b>4001 Ritchie Hgy. Baltimore, Md. 21225</b>	



M-460

70 12771

BALTIMORE CITY HEALTH DEPARTMENT

70 12771

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. \_\_\_\_\_

BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <b>MILDRED MILLER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>December 29, 1970 2:10 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>1514 Pentridge Apt. 157</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 29, 1970 2:10 P.M.</b>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
6. SEX <b>Female</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>SEP 18 1894</b>		10. AGE (In years last birthday) <b>76</b>		E. STREET AND NUMBER <b>1514 Pentridge Apt. 157</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>ROBERT L. MCCLAYTON</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>EDUCATION</b>		15. MOTHER'S MAIDEN NAME <b>EMMA P. STEVENS</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>213-26-3694</b>		18. INFORMANT <b>GERRY NEW ACADEMY</b>	
19. <b>412.2</b>		CAUSE OF DEATH <b>Hypertensive cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION <b>9</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>December 29, 1970</b> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12/29/1970</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. John's Roman Catholic</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Talley</b>	
25C. FUNERAL DIRECTOR <b>Wm. E. Johnson</b>		25D. ADDRESS <b>521 Loch Raven</b>		25E. CITY <b>Baltimore</b>	

Johns Hopkins  
School of Medicine  
725 N. Wolfe

NO 151

NO 151

RECEIVED

↑



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. NAME OF DECEASED  
(Type or Print)

Elizabeth A. Meadows

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Hopkins Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

12

29

70

9:52 a

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

6. SEX

female

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

Nov 13 1970

10. AGE (In years  
lost birthday)11 Under 1 Yr. 11 Under 24 Hrs.  
Months Days Hours Min.

1 1/2

E. STREET AND NUMBER

2119 E. Pratt St.

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF

U.S.A.

13. FATHER'S NAME

GEORGE R. MEADOWS

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

NONE

14B. KIND OF BUSINESS OR INDUSTRY

CHILD

15. MOTHER'S MAIDEN NAME

HELEN BAILY

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, near up known) (If yes, give war or dates of service)

NO

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

LUCILLE MEADOWS 156 N HAVEN ST 31224

19.

795X 1

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Sudden Death In Infancy  
DUE TO, OR AS A CONSEQUENCE OF:ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)22E. INJURY OCCURRED.  
WHILE AT ☐ NOT WHILE  
m. WORK AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

Deputy Chief Medical Examiner

DATE SIGNED

12/29/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

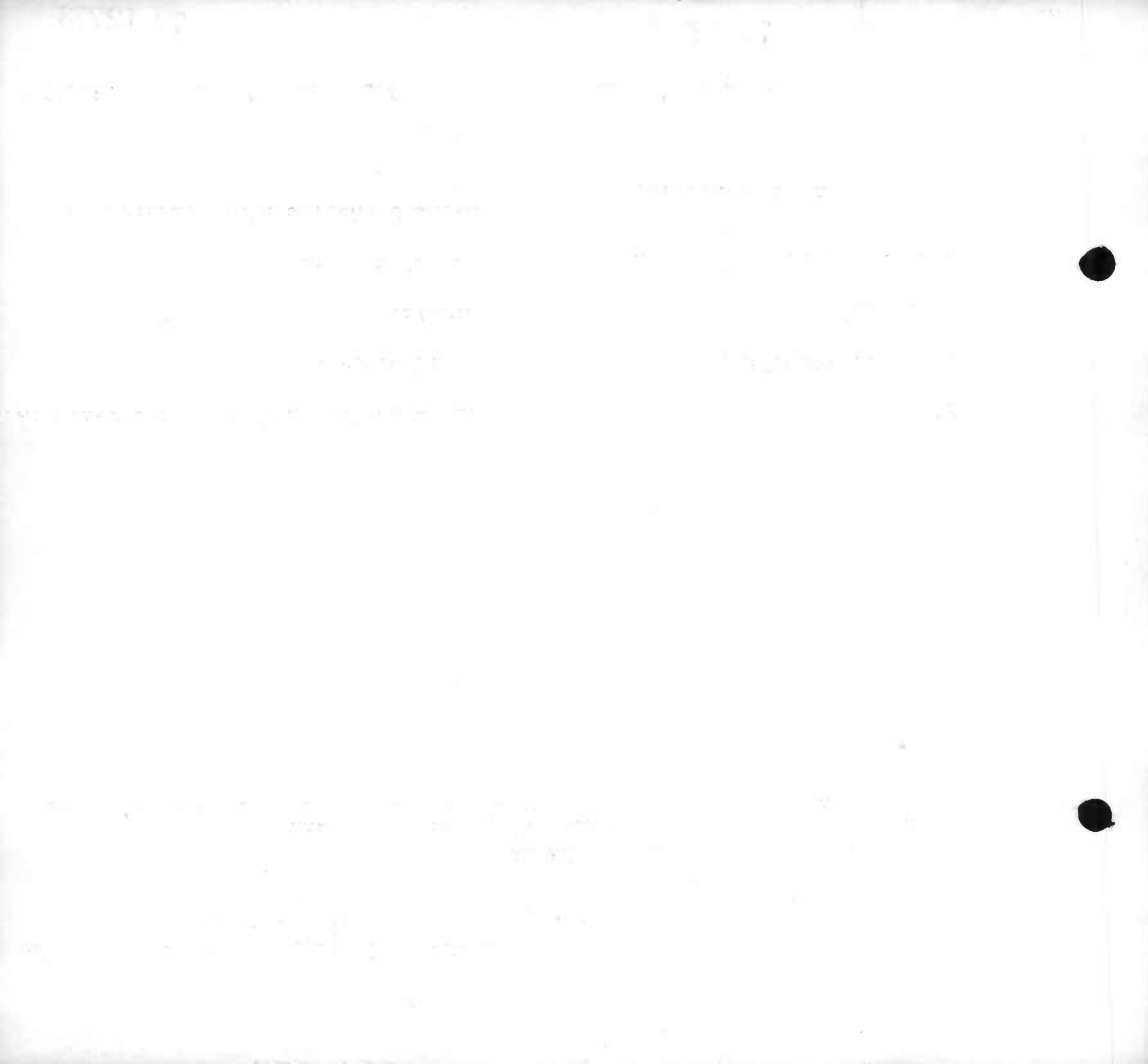
JAN 4 1971

Robert E. Taylor, M.D.

Dipper Bros Inc 1800 Lombard St.



4-230		70 12773		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO.		70 12773	
BIRTH NO.											
1. NAME OF DECEASED (Type or Print)						2. DATE AND HOUR OF DEATH					
PACKWOOD, LAURA						DECEMBER 28, 1970 2:30PM M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						A. STATE B. COUNTY					
ST AGNES HOSPITAL						MARYLAND Howard 63-00					
5. SEX 6. RACE						7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					
FEMALE WHITE						8. DATE OF BIRTH 9. AGE (in years last birthday) 10. AGE (in years last birthday)					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						11. BIRTHPLACE (State or foreign country)					
HOUSEWIFE own Home						MICHIGAN U S A					
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
CLARENCE PACKWOOD RYON						ANNIE MC CALL					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.					
NO						17. INFORMANT ADDRESS					
						ST AGNES HOSPITAL WILKENS & CATON AVE					
18. CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH						L L L pneumonia					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES						(B) DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(C) DUE TO, OR AS A CONSEQUENCE OF:					
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION						19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)						21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)						21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (X) (this hospital) attended the deceased from DECEMBER 20 1970 to DECEMBER 28, 1970 that (X) (we) last saw the deceased alive on DECEMBER 28 1970 and that (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (X) view the body after death.						20A. AUTOPSY? (Yes or No) YES					
23A. SIGNATURE						20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
Ching Hui Tsai, M.D. DEGREE						(If in Baltimore City, give exact location)					
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS					
Ching - Hui Tsai, M.D. DEGREE						BALTIMORE MD 21229					
24A. BURIAL CREMATION, REMOVAL (Specify)						24B. DATE					
Burial						12/30/70					
24C. NAME OF CEMETERY or CREMATORY						24D. LOCATION (City, town, or county) (State)					
Grace Church Cemetery						Elkridge, Maryland					
25A. DATE REC'D BY HEALTH DEPT.						25B. NAME OF REGISTRAR					
JAN 4 1971						Robert E. Taylor, Jr.					
25C. FUNERAL DIRECTOR						ADDRESS					
Ambrose Inc						1328 Sulphur Sp. Rd.					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12774</u>
G-642 70 12774		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>HELEN Novak GORALSKI</u>		2. DATE AND HOUR OF DEATH <u>Dec. 26, 1970</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>3418 Mayfield Avenue</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY _____ C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3418 Mayfield Avenue</u> <u>2633</u>		
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/14/19</u>	9. AGE (in years last birthday) <u>51</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Bendix Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Edward Novak</u>		
14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>215-05-8317</u>		
16. SOCIAL SECURITY NO. <u>215-05-8317</u>		17. INFORMANT <u>Herman J. Goralski, husband, above</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Coronary - Myocardial Infarct - Immediate</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Coronary Artery Disease - Atherosclerosis 2 yrs.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>12/23</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>12/23</u> 19 <u>70</u> to <u>12/23</u> 19 <u>70</u> and that (I) (we) lost saw the deceased alive on <u>12/23</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Joseph J. Cameron</u>		23B. DATE SIGNED <u>12/26/70</u>		23C. PHYSICIAN'S NAME (Type) <u>JOSEPH J. CAMERON</u>
23D. ADDRESS <u>1012 Old North Pt Rd Balto 24</u>		23E. DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>12/29/70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 4 1971</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home Inc.</u> <u>3331 Brehms Lane</u>		



BALTIMORE CITY HEALTH DEPARTMENT				70 12775			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.			
BIRTH NO.				70 12775			
1. NAME OF DECEASED (Type or Print) <b>EZEKIEL HUNDLEY</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> <b>December 30, 1970</b>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>LUTHERAN HOSPITAL (DOA)</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 30, 1970 2:30 P.M.</b>			
6. SEX <b>Male</b>				7. RACE <b>Negro</b>			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
9. DATE OF BIRTH <b>8-22-24</b>				10. AGE (In years last birthday) <b>46</b>			
11. BIRTHPLACE (State or foreign country) <b>Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Charles Hundley</b>				14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
15. MOTHER'S MAIDEN NAME <b>Mary Good</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes 8/11/43-5/14/46</b>			
17. SOCIAL SECURITY NO.				18. INFORMANT <b>Lillian Phillips</b>			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>2</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) <b>Yes</b>				22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING			
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>House</b>				22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>934 N. Stricker St.</b>			
22D. TIME OF INJURY (APPROX.) <b>12-30-70 ?</b>				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22F. HOW DID INJURY OCCUR? <b>Shot self (thought gun was empty)</b>				23.			
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED			
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				December 31, 1970			
ACTUAL EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>1-4-71</b>				24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Fr.</b>			
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>				25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1971</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>				25C. FUNERAL DIRECTOR <b>V. Bailey</b>			
ADDRESS <b>1348 Calhoun St.</b>				25D. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1971</b>			

8751 05

8751 05

UNITED STATES DEPARTMENT OF COMMERCE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

RECEIVED

NOV 11 1918

NOV 11 1918

TO THE SECRETARY OF COMMERCE

FROM THE SECRETARY OF COMMERCE

NOV 11 1918

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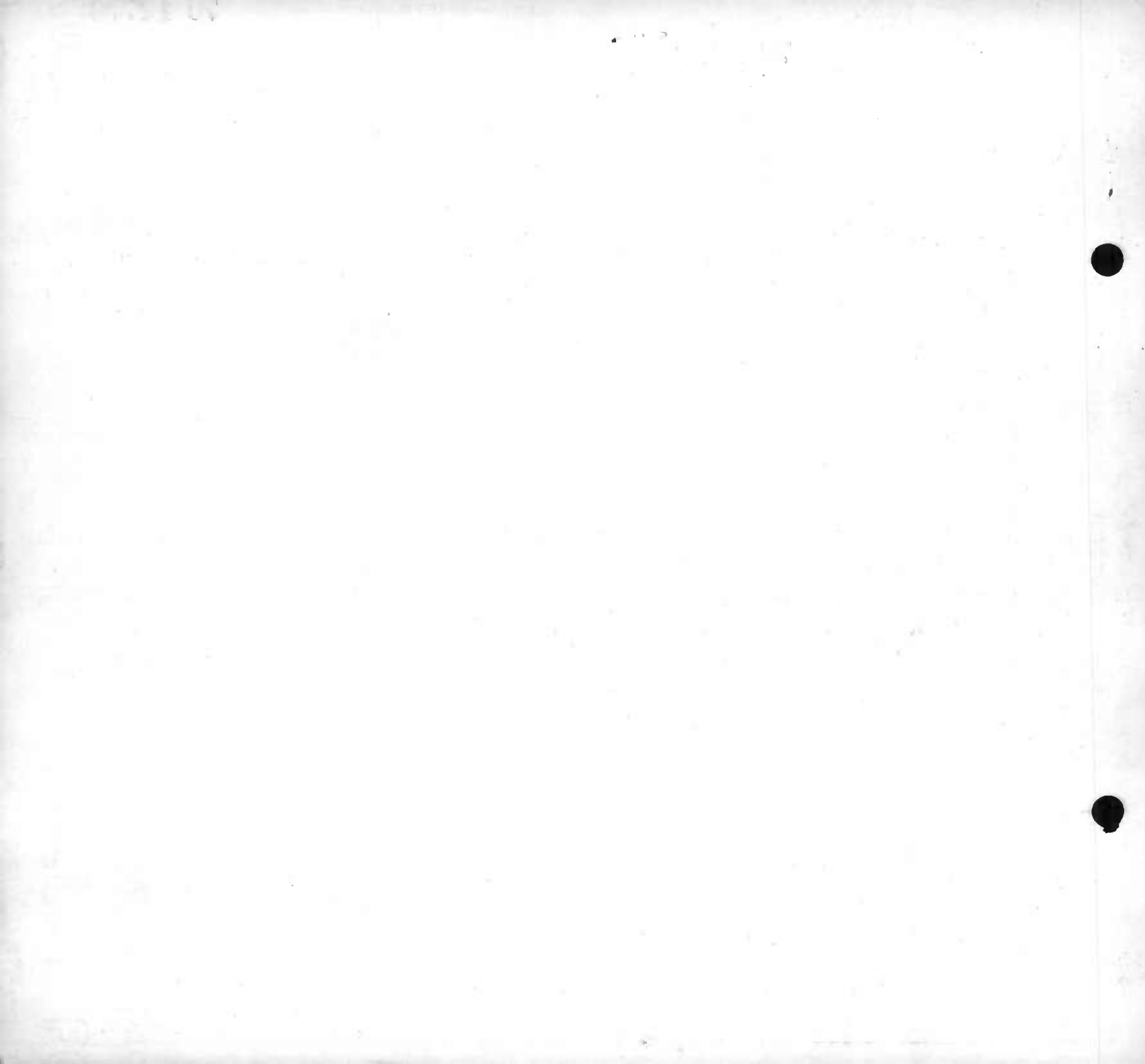
NOV 11 1918

ACQUITTANCE

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

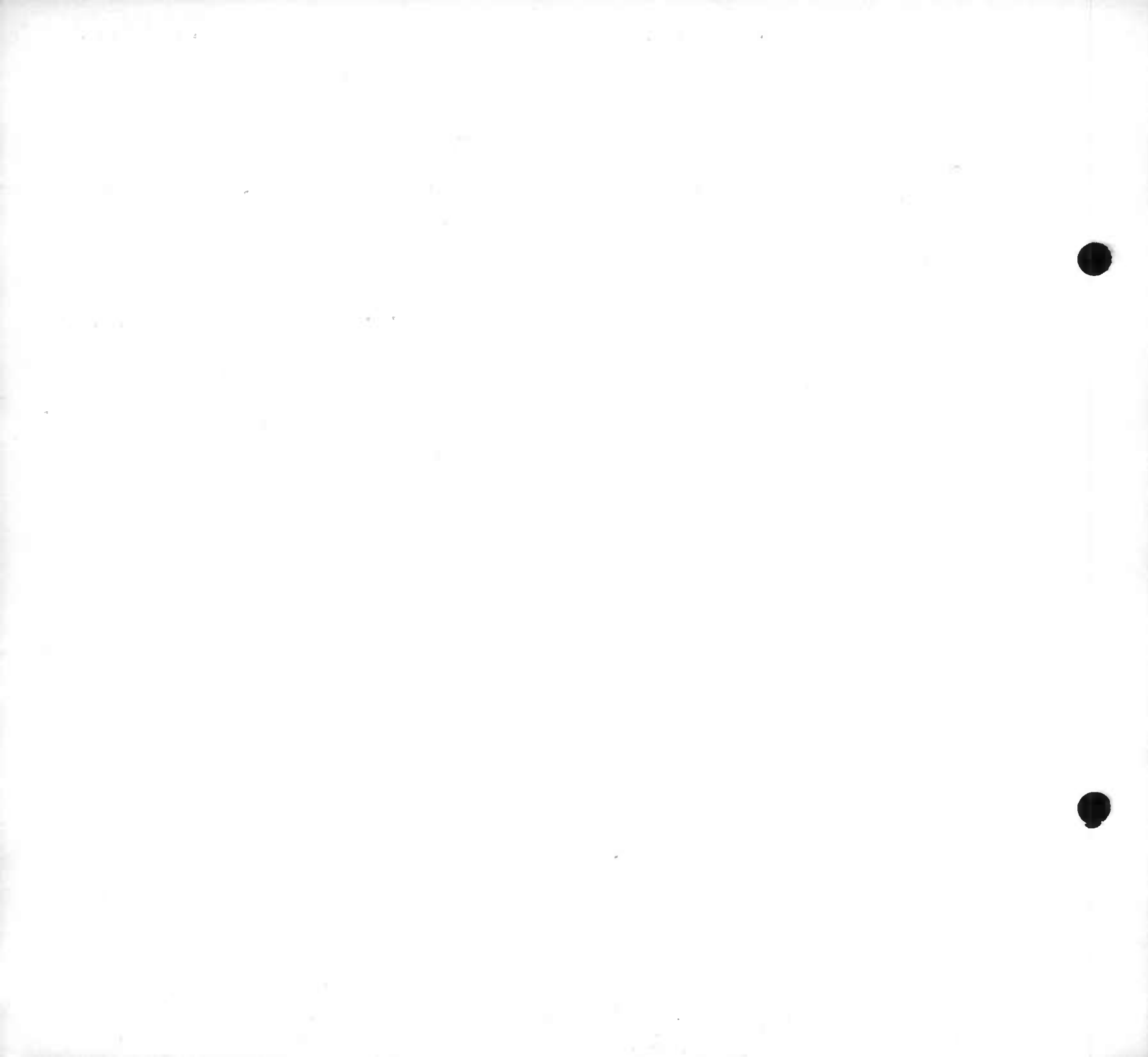
BALTIMORE CITY HEALTH DEPARTMENT				70 12776	
F-635 BIRTH NO. 70-14143				70 12776	
1. NAME OF DECEASED (Type or Print)				CLIFTON FRIEDMAN	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
THE JOHNS HOPKINS HOSPITAL				MARYLAND BALTIMORE CITY	
5. SEX MALE				6. RACE NEGRO	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 3-8-70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				9. AGE (In years lost birthday) 9	
10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME HENRY FRIEDMAN				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				14. MOTHER'S MAIDEN NAME ELLA PIERCE	
16. SOCIAL SECURITY NO.				17. INFORMANT Lula Pierce 1349 Fremont Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: INTRACRANIAL HEMORRHAGE (B) CONGENITAL HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF: (C)	
MEDICAL CERTIFICATION				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-6-70 to 19-70, that (I) (we) last saw the deceased alive on N/A 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John P. Pacanowski, M.D. DEGREE				23B. DATE SIGNED 30 DEC 1970	
23C. PHYSICIAN'S NAME (Type) JOHN P. PACANOWSKI DEGREE				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-4-71		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION Balto. Md.		24E. NAME OF REGISTRAR V. Bailey			
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1971		25B. NAME OF REGISTRAR Robert C. Bailey, M.D.		25C. FUNERAL DIRECTOR Kelson F.H. 1348 Calhoun St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 12777		70 12777	
S-320				70 12777		70 12777	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				SHILEY STAGGS		12/28/70 12:15 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		5. CITY OR TOWN	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				Maryland		Baltimore	
Montebello State Hospital				E. STREET AND NUMBER		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
217 Ballou Ct.				3061231			
6. SEX M		6. RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/10/04	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) 66		11. BIRTHPLACE (State or foreign country) S.C.	
13. FATHER'S NAME Jim Stagg				14. MOTHER'S MAIDEN NAME Maggie King			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT Ruth Staggs (wife)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 4/10/9 14-189.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Metastatic Carcinoma urethra				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Probably M. Infarction (B) Coronary occlusion (C) DUE TO, OR AS A CONSEQUENCE OF: DUE TO, OR AS A CONSEQUENCE OF: DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. DATE OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Dr. C. Parra	
23B. DATE SIGNED 12/28/70		23C. PHYSICIAN'S NAME (Type) DR. C. PARRA		23D. ADDRESS Montebello State Hospital		23E. FUNERAL DIRECTOR Kelson P.H. 1348 Calhoun St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-31-70		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1971		25B. NAME OF REGISTRAR R. C. F. F. F.		25C. ADDRESS Kelson P.H. 1348 Calhoun St.		25D. ADDRESS Kelson P.H. 1348 Calhoun St.	

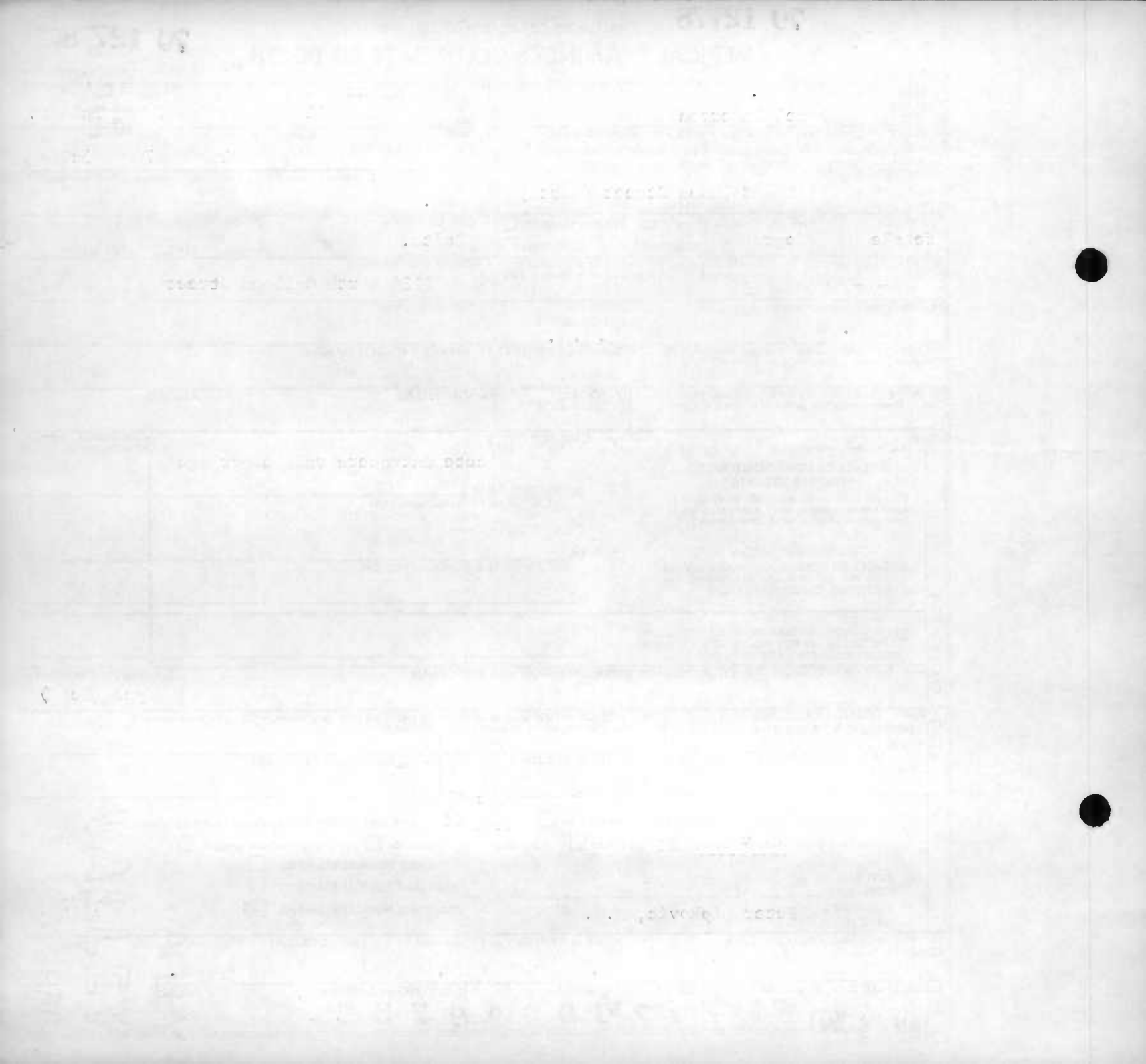


BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 12778

BIRTH NO. \_\_\_\_\_ REG. NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) Hazel Anderson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 28 Year 70 Hour 3:10 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1136 Calhoun Street (North)		3. DATE PRONOUNCED DEAD Month 12 Day 28 Year 70 Hour 3:10 a.m.	
6. SEX female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 3-1-19		10. AGE (In years lost birthday) 51	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Bessie Wormsey		16. STREET AND NUMBER 1136 North Calhoun Street 1602	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Eleanora Anderson 918 Cherryhill Rd.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute intracerebral hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 12/28/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-4-71	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1971		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR V. Bailey		ADDRESS 1348 Calhoun Street	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12779</u>	
BIRTH NO. <u>520</u>		70 12779		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <u>LAURA V. JONES</u>			2. DATE AND HOUR OF DEATH <u>12/27/70</u> <u>8:51 PM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital of MD</u>			A. STATE <u>Maryland</u>		
			B. COUNTY <u>Prince Georges</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Catonsville</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2 Robert Ave.</u>		<u>5300</u>
5. SEX <u>F</u>	6. RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/5/11</u>	9. AGE (In years last birthday) <u>59 yrs</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>IRA Williams</u>			14. MOTHER'S MAIDEN NAME <u>Nettie B. Dorsey</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>William H. Jones 2 Robert Ave.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>RENAL FAILURE</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>HYPERTENSIVE ARTERIOLAR NEPHROSCLEROSIS.</u>		
			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>HYPERTENSION (ESSENTIAL)</u>		
			(C) <u>ASCVD and CHF</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>No injury</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>12/19/70</u> to <u>12/27/70</u> that (I) (we) lost saw the deceased alive on <u>12/27/70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>K. George Thomas MD</u>					23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <u>K. GEORGE THOMAS MD</u>			23D. ADDRESS <u>Lutheran Hospital of MD</u>		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>	<u>1-2-71</u>	<u>West Liberty Cemetery</u>		<u>Howard Co. MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 4 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Kelson Funeral Home 1348 N. Calhoun St.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12780</u>	
70 12780				CERTIFICATE OF DEATH	
BIRTH NO. <u>D-520</u>		1. NAME OF DECEASED (Type or Print) <u>Dennis, William T.</u>		2. DATE AND HOUR OF DEATH <u>12/30/70</u> <u>7:15</u> a. m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>Provident Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>2600 Liberty Heights Ave. Baltimore, Maryland 21215</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____ C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2425 Madison Ave.</u> <u>1301</u>		
5. SEX <u>Male</u>	6. RACE <u>Negroid</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/7/92</u>	9. AGE (In years lost birthday) <u>78</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State of foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Jacob Dennis</u>			14. MOTHER'S MAIDEN NAME <u>Teressa Smith</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>220207439</u>		17. INFORMANT <u>John Dennis-Brother</u> <u>Mrs. Adalaide Cully-Sister</u> ADDRESS <u>1900 Chelsea Rd.</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Terminal Bronchopneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>Chronic Lung Disease with</u> <u>4 weeks pleural effusion</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 years</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION _____		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <u>12/29/70</u> 19____ to <u>12/30/70</u> 19____ that (I) (we) last saw the deceased alive on <u>12/30/70</u> 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. K. E. M.D.</u>				23B. DATE SIGNED <u>Dec. 30, 1970</u>	
23C. PHYSICIAN'S NAME (Type) <u>VENIEDO ALIDIO MD</u>				23D. ADDRESS <u>2600 Liberty Heights Ave. Baltimore Md.</u>	
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-4-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cem.</u>	
24D. LOCATION <u>Balto., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 4 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>V. Bailey</u> <u>Kelson F.H.</u> ADDRESS <u>1348 Calhoun St.</u>			



70 12781

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 12781

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>FRANK GOLEMBIESKI</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>JOHNS HOPKINS HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 30, 1970 11:26 P.</b> M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
9. DATE OF BIRTH <b>10-4-1894</b>		10. AGE (In years lost birthday) <b>76</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Elec. Co.</b>	
15. MOTHER'S MAIDEN NAME <b>Mary</b>		13. FATHER'S NAME <b>Andrew</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>WW-1</b>		17. SOCIAL SECURITY NO. <b>212-05-6094</b>	
18. INFORMANT <b>A. Golembieski</b>		ADDRESS <b>4770 Homesdale Ave</b>	
19. <b>4124</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes (Head-Only)</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> (Head-Only) and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <b>12/30/70</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-2-71</b>	
24C. NAME of CEMETERY or CREMATORY <b>St. Stanislaus Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. J. [illegible]</b>	
25C. FUNERAL DIRECTOR <b>B. Dabrowski</b>		ADDRESS <b>2818 E. Balto. St.</b>	

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1851 17

MADE IN GERMANY

1

R-230

70 12782

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 12782

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>NANCY L. ROSKOTT</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>5621 Green Hill Road</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 30, 1970 8:10 P.</b> M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
6. SEX <b>Female</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <b>10/6/1913</b>	10. AGE (in years lost birthday) <b>57</b>	If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER <b>5621 Green Hill Road 2641</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>W. Laurance Cranston</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
14B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		15. MOTHER'S MAIDEN NAME <b>Mary C. Haile</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>213-18-1049</b>	
18. INFORMANT <b>Bernard W. Roskott</b>		ADDRESS <b>1105 Meridene Dr.</b>	
19. <b>5718</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Fatty metamorphosis of liver</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> <b>December 31, 1970</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1/2/71</b>	24C. NAME OF CEMETERY or CREMATORY <b>Fork Meth. Church Cen.</b>	24D. LOCATION (City, town, or county) (State) <b>Fork Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 4 1971</b>		25B. NAME OF REGISTRAR <b>R. E. Jenkins</b>	25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Rd. Balto., Md. 21212</b>

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70 12783 BALTIMORE CITY HEALTH DEPARTMENT

70 12783

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

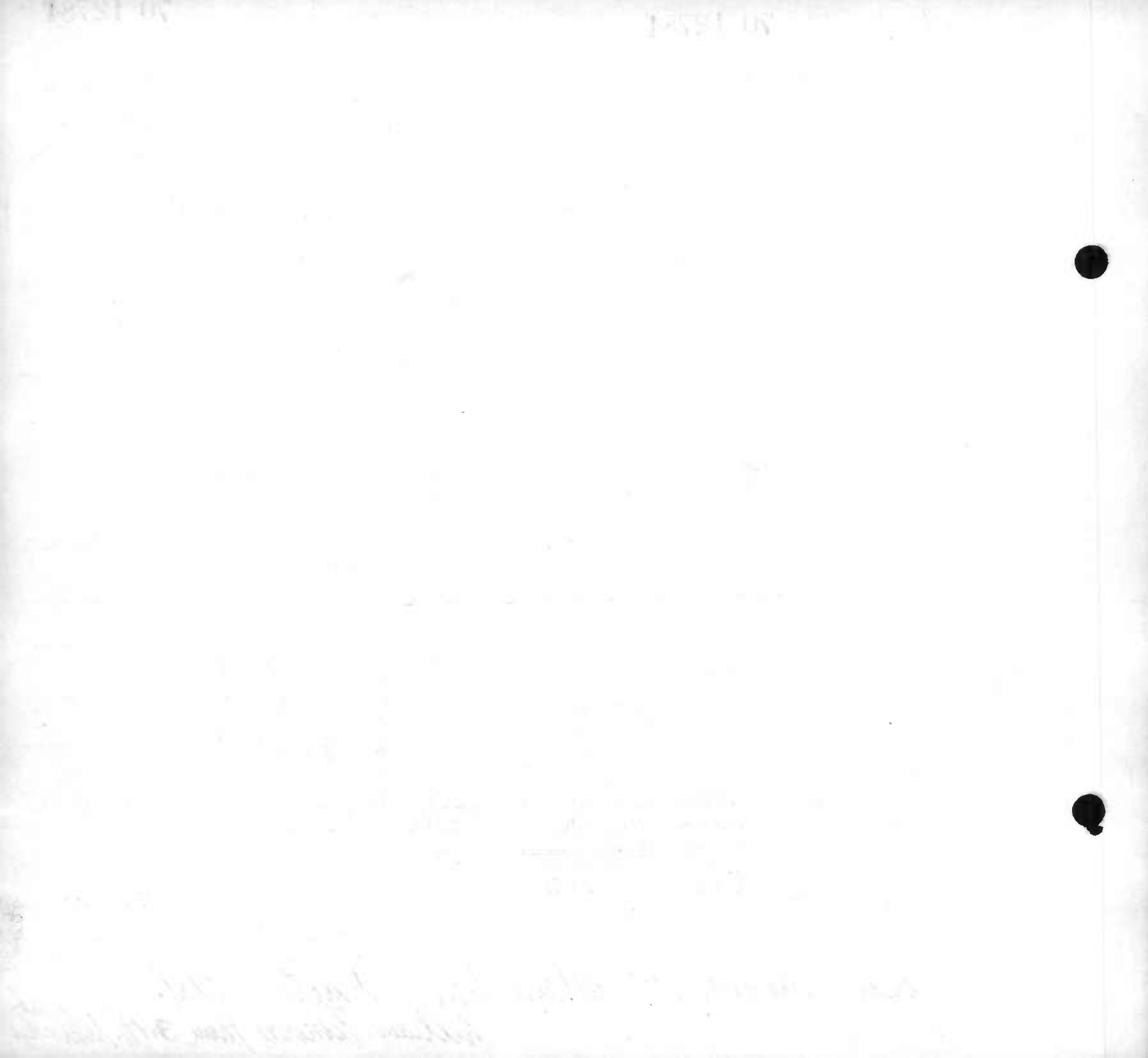
1. NAME OF DECEASED (Type or Print) ALTA M. GRAFTON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year December 31, 1970 5:15 P. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 3/22/1893		10. AGE (In years lost birthday) 77 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Oregon		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Md. Casualty-Office Insurance		14B. KIND OF BUSINESS OR INDUSTRY Insurance	
15. MOTHER'S MAIDEN NAME Emma V. McCann		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 212-10-3447		18. INFORMANT Nathan Grafton, 232 Stevenson Lane	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E 717 X Subdural Hematoma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Street	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12-31-70 1:35 P. m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Unit block of West North Avenue		22F. HOW DID INJURY OCCUR? Subject struck head	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) yes	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1/1/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/4/71	
24C. NAME OF CEMETERY or CREMATORY Dublin Southern Cem.		24D. LOCATION (City, town, or county) (State) Dublin Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 4 1971		25B. NAME OF REGISTRAR J. W. Jenkins	
25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4905 York Rd., Balto., Md. 212	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

U-126		70 12784		BALTIMORE CITY HEALTH DEPARTMENT		70 12784	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>Viola Upshur</b>				2. DATE AND HOUR OF DEATH <b>29<sup>th</sup> Dec. 1970 10:35 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>University of Maryland Hospital</b>				A. STATE <b>Maryland</b>		B. COUNTY	
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>657 W. Mulberry St. 402</b>			
5. SEX <b>Female</b>		6. RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>21 Sept. 1914</b>	
				9. AGE (in years last birthday) <b>56</b>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John Ponglee</b>				14. MOTHER'S MAIDEN NAME <b>Mary Guy</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Rita Burnette</b>	
				ADDRESS <b>657 W. Mulberry St.</b>			
18. <b>183.01</b> CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>probable gram neg. sepsis</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>metastatic carcinoma, primary site unknown</b> DUE TO, OR AS A CONSEQUENCE OF: <b>probably ovarian</b>			
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (B) (this hospital) attended the deceased from <b>29<sup>th</sup> Dec. (6:00 AM)</b> 19 <b>70</b> to <b>29<sup>th</sup> Dec. (11:35 AM)</b> 19 <b>70</b> that (B) (we) last saw the deceased alive on <b>29<sup>th</sup> Dec.</b> 19 <b>70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (B) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Raymond E. Knowles Jr. M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>29<sup>th</sup> Dec. 70</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <b>University of Maryland Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>Jan. 4/1971</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D. BY HEALTH DEPT. <b>JAN 4 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>		25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>		ADDRESS <b>3197 N. Lakeside</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

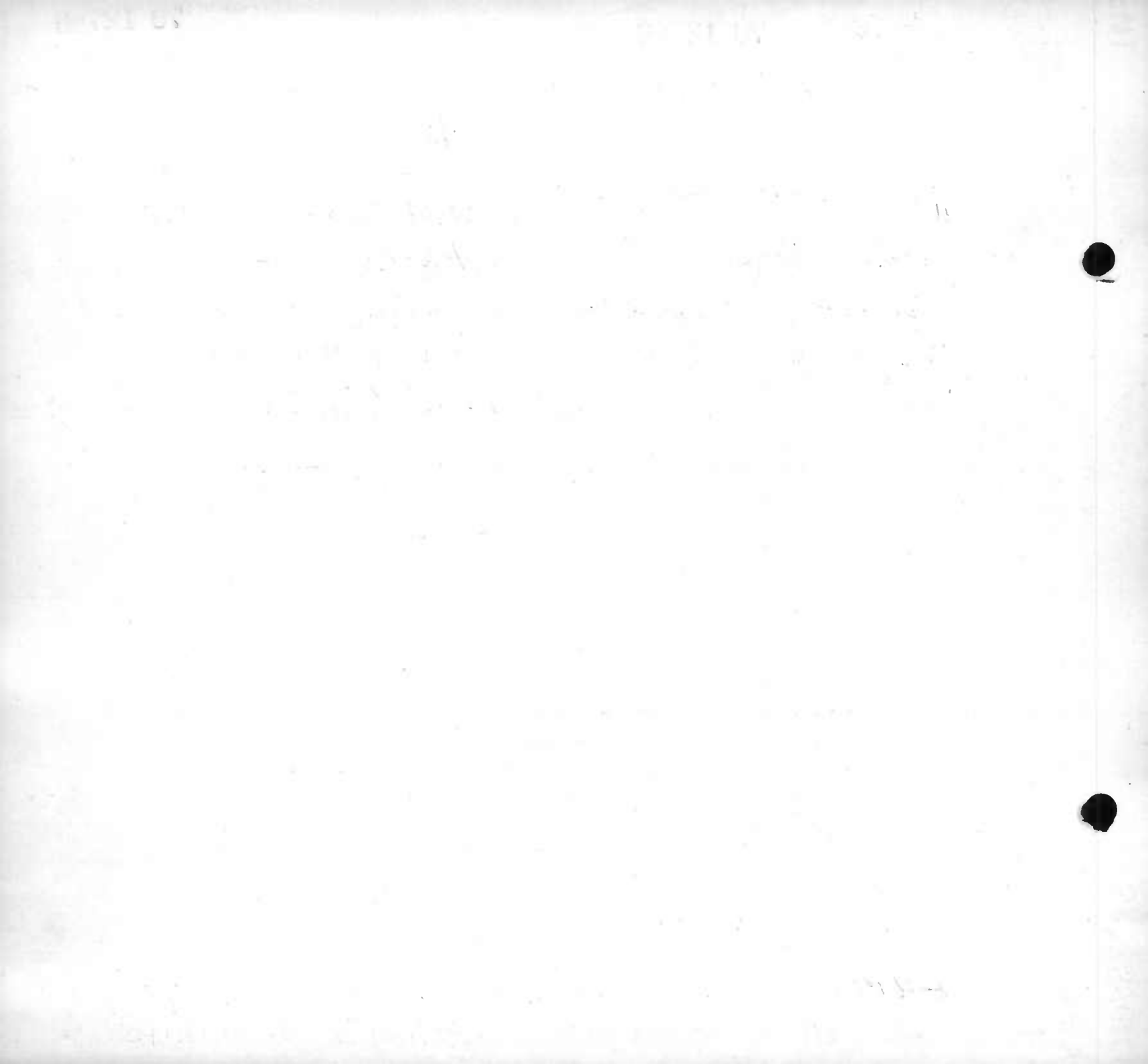
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 12785</u>	
<b>BIRTH NO.</b> <u>R-525</u> <b>1. NAME OF DECEASED</b> (Type or Print) <u>BABY GIRL RANSOM</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>12/30/70</u> <u>16:05 AM.</u>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>PROVIDENT HOSPITAL</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <u>Maryland</u> <b>B. COUNTY</b> <b>C. CITY OR TOWN</b> <u>Baltimore</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>748 Poplar Grove Street</u> <u>1606</u>			
<b>5. SEX</b> <u>F</u>	<b>6. RACE</b> <u>N</u>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>12/28/70</u>	<b>9. AGE</b> (In years last birthday) <u>2</u>	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) 
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) 		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> 		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MD.</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>
<b>13. FATHER'S NAME</b> <u>John Euret</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Justina Ransom</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) 		<b>16. SOCIAL SECURITY NO.</b> 		<b>17. INFORMANT</b> <u>Justina Ransom-Mother</u>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 		<b>CAUSE OF DEATH</b> <b>(A) IMMEDIATE CAUSE</b> <u>NEONATAL SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF: <b>(B) <u>PREMATURITY</u></b> DUE TO, OR AS A CONSEQUENCE OF: <b>(C) _____</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 D.</u> <u>2 D.</u>	
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> 		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> 		<b>20A. AUTOPSY?</b> (Yes or No) <u>YES</u>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from <u>12/28</u> 19 <u>70</u> to <u>12/30</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>12/30</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (<del>did not</del>) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>Dwight N. Fortner MD</u>				<b>23B. DATE SIGNED</b> <u>12/30</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>DWIGHT N. FORTNER</u>				<b>23D. ADDRESS</b> <u>UNIV. HOSP. - DEPT. OF PEDIATRICS</u>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>24B. DATE</b> <u>12/31/70</u>		<b>24C. NAME of CEMETERY or CREMATORY</b> <u>Mt. Auburn</u>	
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Baltimore</u> <u>MD.</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JAN 5 1971</u>			
<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Taylor</u>		<b>25C. FUNERAL DIRECTOR</b> <u>William J. Phillips</u>			
<b>25D. ADDRESS</b> 					



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12786</u>	
C-516		70-12786		<b>CERTIFICATE OF DEATH</b>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Good (Eligman) Chambers</u>		2. DATE AND HOUR OF DEATH <u>30-Dec-70 5:01 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Balt. General Hosp</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>		6. RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>4-16-08</u>		9. AGE (In years last birthday) <u>62</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Gas and Electric</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
13. FATHER'S NAME <u>Weldon Chambers</u>		14. MOTHER'S MAIDEN NAME <u>Mary Watts</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-05-5111</u>		17. INFORMANT <u>Wife - Madge Chambers - Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u>		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction</u> (B) <u>Hypertensive Cardiovascular Disease</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>					
21A. DATE OF OPERATION <u>0</u>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		22A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>30-Dec</u> 19 <u>70</u> to <u>30-Dec</u> 19 <u>70</u> , that <u>(H)</u> (we) last saw the deceased alive on <u>30-Dec</u> 19 <u>70</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard E Fisher MD</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>30-Dec-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Richard E Fisher MD</u>		23D. ADDRESS <u>South Baltimore Gen. Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-4-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mount Auburn</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor JR</u>		25C. FUNERAL DIRECTOR <u>Arlington S. Phillips</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12787	
K-520 70 12787		CERTIFICATE OF DEATH		70 12787	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		335 P M.	
Deidra R. King		12/29/70			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
39 Provident Hospital		Maryland			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	
Female		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Unemployed				1/6/49	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
Charles King		Bessie Harris		21	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)	
No		216-58-3819		Maryland	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		17. INFORMANT		12. CITIZEN OF WHAT COUNTRY?	
2539 I		Bessie King 2811 Chelsea Terrace		U.S.A.	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Cardiac Arrest	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		Hypothalamic Infarction	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:		Pituitary Adenoma	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1/31/70 19 to 12/29/70 19, that (I) (we) last saw the deceased alive on 12/29/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
HOLUS JENNARINE, MD		12/30/70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
HOLUS JENNARINE, MD		2425 Eutaw Place			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/31/70		Arbutus Memorial Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 5 1971		Robert E. Fisher, M.D.		Arlington S. Phillips	
				1727 North Monroe St.	

18/12/10

18/12/10

18/12/10

18/12/10

18/12/10

18/12/10

18/12/10

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

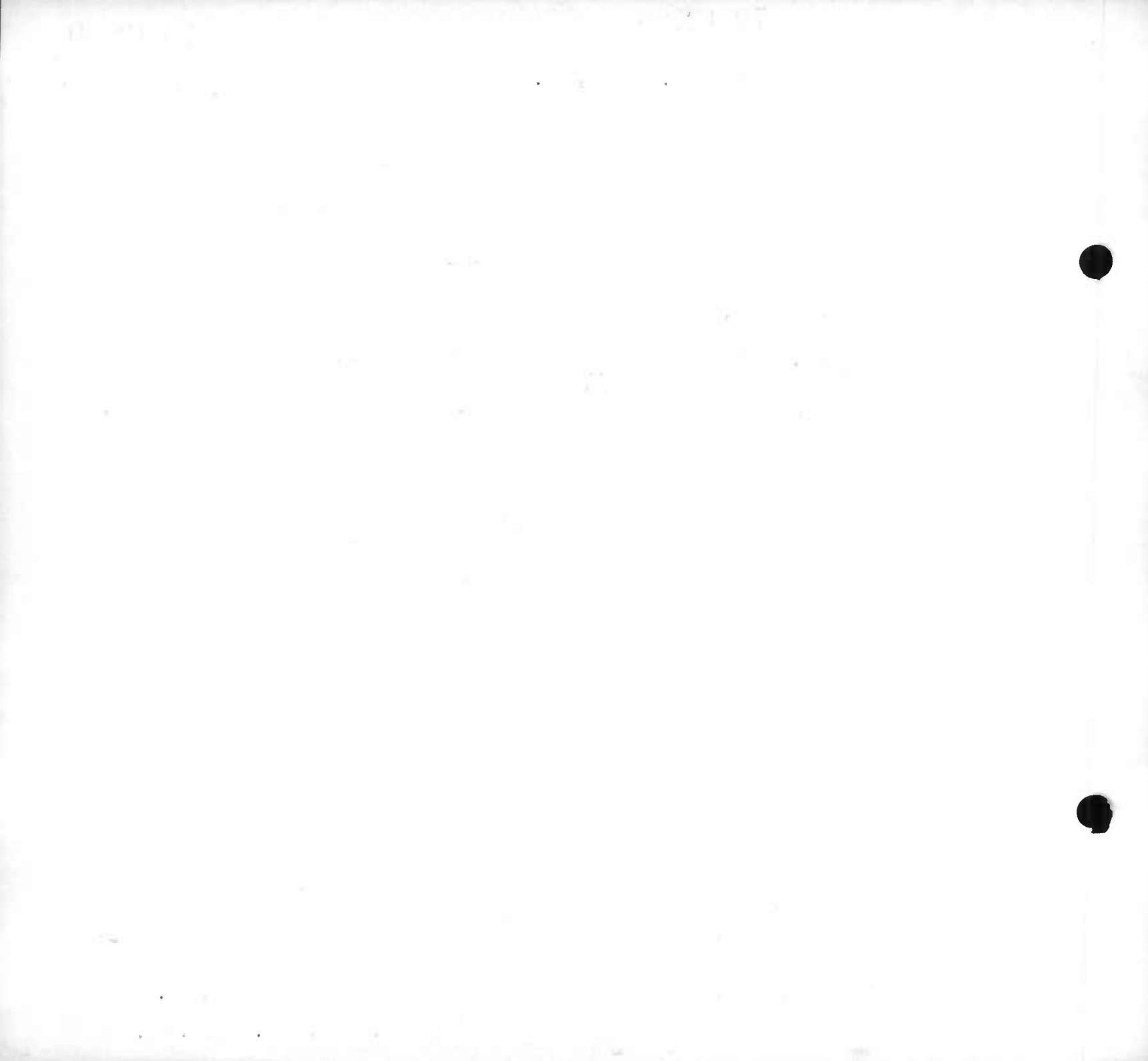
BALTIMORE CITY HEALTH DEPARTMENT						REG. NO. <u>70 12788</u>
70 12788						CERTIFICATE OF DEATH
S-530 BIRTH NO.			1. NAME OF DECEASED (Type or Print) <u>Smith, Walter A.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			2. DATE AND HOUR OF DEATH <u>12/28/70</u> <u>8:30</u> p. M.			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42</u> <u>Sinai Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>4900 Haddon Avenue</u>			<u>2841</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/24/13</u>	9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Hauswald's Bakery</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Smith</u>			14. MOTHER'S MAIDEN NAME <u>Estella Sugars</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-09-7305</u>		17. INFORMANT <u>Mrs. Viola H. Smith</u>		ADDRESS <u>4900 Haddon Avenue</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction acute</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Atherosclerotic coronary artery disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____						
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>10-14</u> 19 <u>70</u> to <u>11-1</u> 19 <u>70</u> , that (I) (we) lost saw the deceased olive on <u>11-1</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <u>Frank G. Kuehn MD</u>			23B. DATE SIGNED <u>12/31/70</u>		23C. PHYSICIAN'S NAME (Type) <u>FRANK G. KUEHN</u>	
23D. ADDRESS <u>721 MED ARTS BLDG. BALTO 1</u>		23E. DATE <u>1/2/71</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. NAME OF CEMETERY or CREMATORY <u>Mount Calvary Cemetery</u>		24C. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor MD</u>		25C. FUNERAL DIRECTOR <u>Arlington S. Phillips</u>		
ADDRESS <u>1727 North Monroe St.</u>						



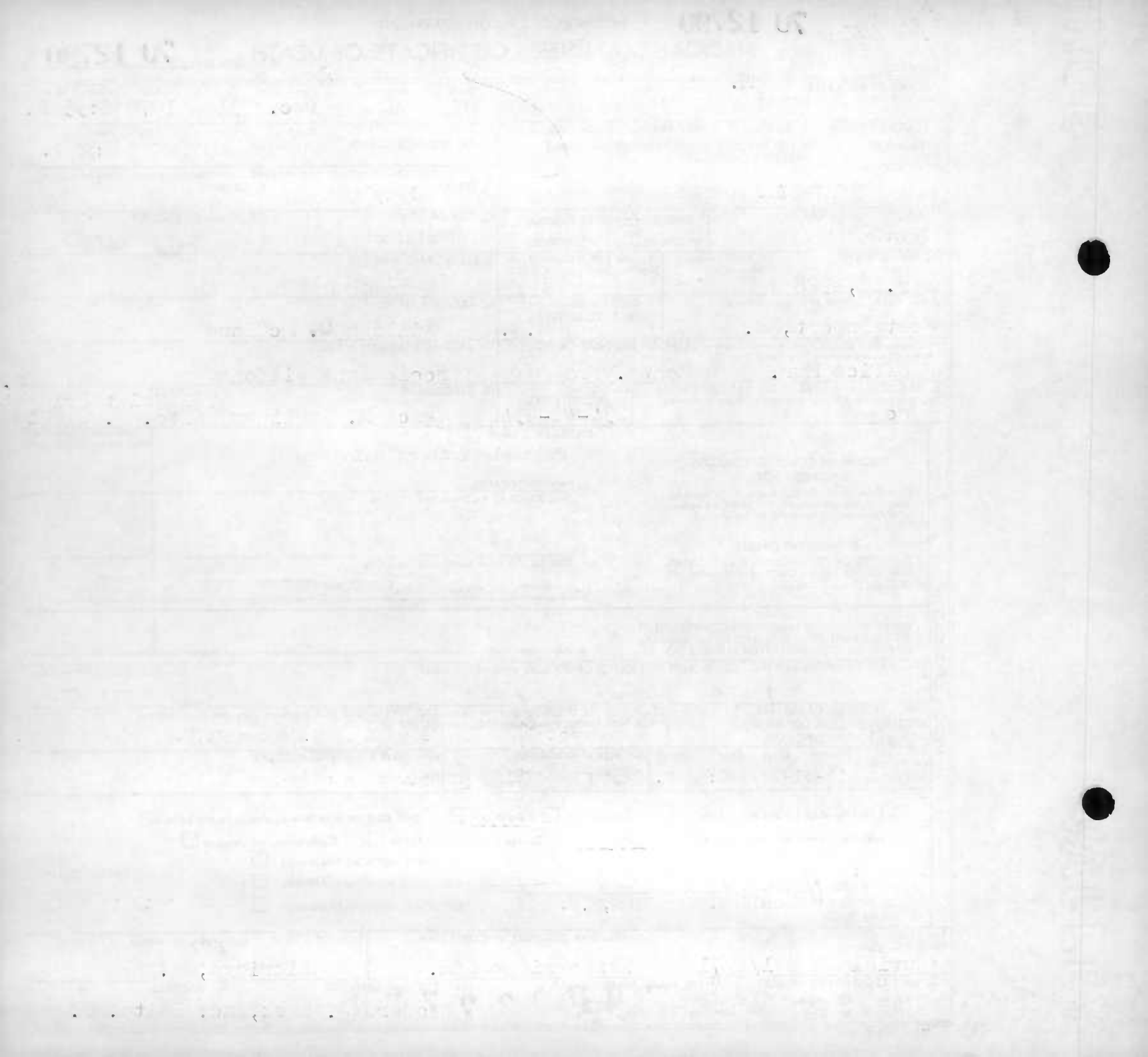
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12789</u>	
<div style="font-size: 2em; font-weight: bold;">F-236</div> <div style="font-size: 2em; font-weight: bold;">70 12789</div>				<div style="font-size: 1.5em; font-weight: bold;">CERTIFICATE OF DEATH</div>	
<div style="display: flex; justify-content: space-between;"> <div> <b>BIRTH NO.</b>  <b>1. NAME OF DECEASED</b>                      (Type or Print) <span style="font-size: 1.2em;">James P. Foster, Jr.</span> </div> <div> <b>2. DATE AND HOUR OF DEATH</b>  <div style="display: flex; justify-content: space-between;"> <span>December 31, 1970</span> <span>10:15 AM</span> </div> </div> </div>					
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <div style="display: flex; justify-content: space-between;"> <div> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>  <span style="font-size: 1.5em;">37</span> <span style="font-size: 1.2em;">MERCY HOSPITAL</span> </div> <div> <b>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</b> </div> </div>				<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution residence before admission) <div style="display: flex; justify-content: space-between;"> <div> <b>A. STATE</b>  <span style="font-size: 1.2em;">Md</span> </div> <div> <b>B. COUNTY</b> </div> </div>	
				<b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span>	
				<b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				<b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">1613 Argonne Drive</span>	
				<span style="font-size: 2em; font-weight: bold;">902</span>	
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">W</span>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">2-4-92</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">78</span>
		<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired Millwork Co. Owner</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Maryland</span>	
<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">James P. Foster</span>				<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Lillian Carroll</span>	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>				<b>16. SOCIAL SECURITY NO.</b>	
				<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Mrs. Carroll Carr, Augusta, Georgia.</span>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <span style="font-size: 1.5em;">41241</span> <span style="font-size: 1.2em;">Cerebral Vas. Accident</span>				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">A.S.C.V.D</span>				<b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <span style="font-size: 1.2em;">Atrial Fibrillation</span>	
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">12/20/70</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">No</span>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">12/20</span> <span style="font-size: 1.2em;">1970</span> <b>to</b> <span style="font-size: 1.2em;">12/31</span> <span style="font-size: 1.2em;">1970</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">12/31</span> <span style="font-size: 1.2em;">1970</span> <b>and that (in my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">Borden Kim</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">12/30/70</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.5em;">Bro Kevin Kim</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.5em;">Mercy Hospital</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">1/2/71</span>		<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Woodlawn Cemetery</span>	
				<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.5em;">JAN 5 1971</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.5em;">Rube E. Jones</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.5em;">Leonard J. Ruck, Inc. Balto. Md. 21214</span>	



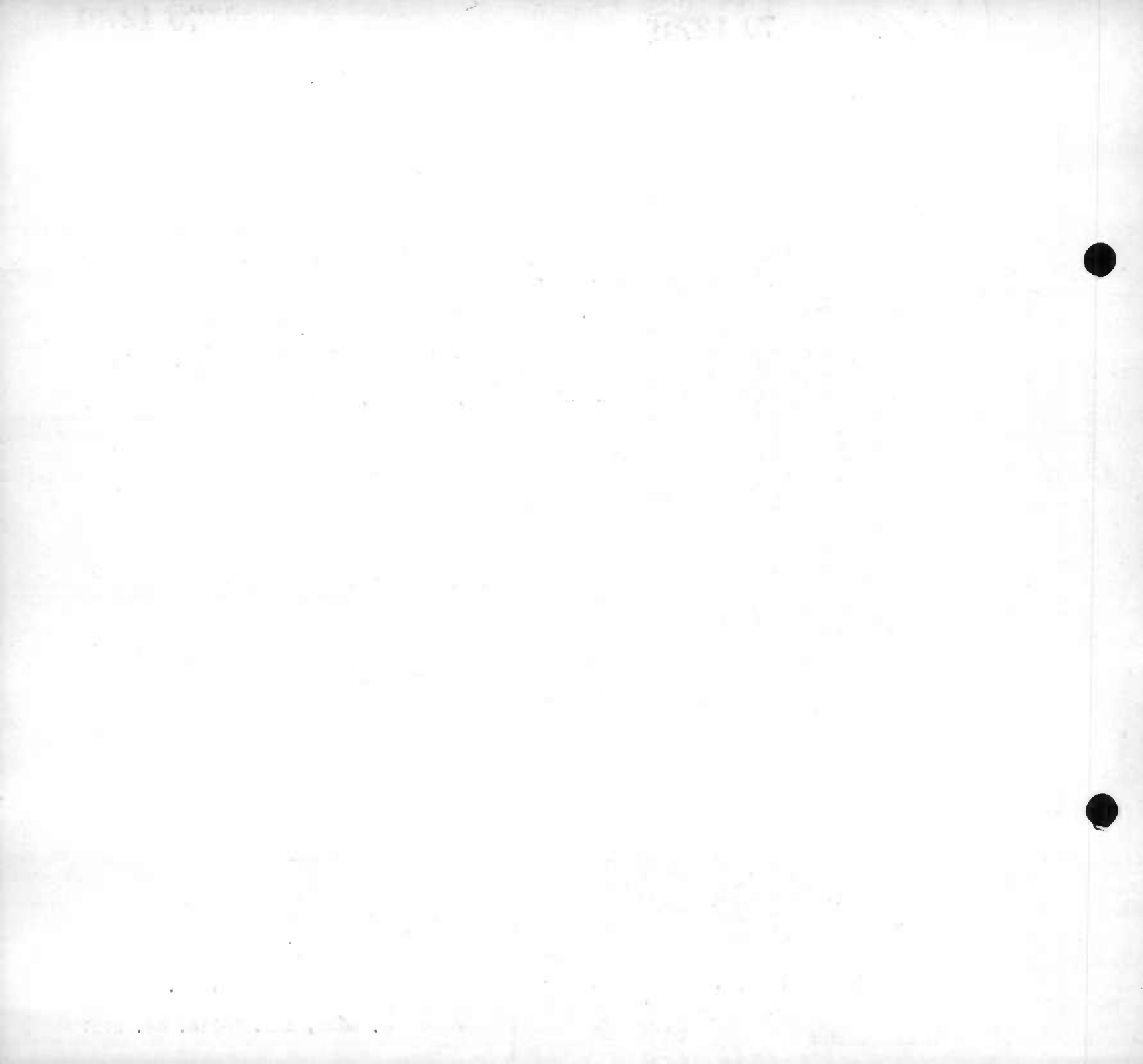
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 70 12790	
1. NAME OF DECEASED (Type or Print) <b>RUTH RAWLINGS</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> Dec. 31 1970 8:55 P. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>38 UNIVERSITY HOSPITAL</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour December 31, 1970 8:55 P. M.			
5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY							
6. SEX <b>Female</b>		7. RACE <b>White</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Apr. 12, 1928</b>		10. AGE (In years lost birthday) <b>42</b>		11. BIRTHPLACE (State or foreign country) <b>Westernport, Md.</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>William C. McCloud</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office Mgr.</b>		15. MOTHER'S MAIDEN NAME <b>Nooie Anne Wilfong</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>234-42-9346</b>		18. INFORMANT <b>Vance M. Rawlings</b>		19. CAUSE OF DEATH <b>Multiple Traumatic Injuries</b>	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1500 Block S. Monroe St, N. of Wicomico St.</b>		22D. TIME OF INJURY (APPROX.) <b>12-31-70 6:00 P. M.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Driver in auto-auto collision</b>		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>1/4/71</b>		24C. NAME of CEMETERY or CREMATORY <b>Meadowridge Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Elkridge, Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1971</b>	
24F. NAME OF REGISTRAR <b>Robt E. J. J. J.</b>		24G. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.</b>		24H. ADDRESS <b>Balto. Md.</b>		24I. DATE SIGNED <b>1/1/71</b>	
24J. ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		24K. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		24L. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		24M. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	



**FUNERAL DIRECTOR: IMPORTANT**

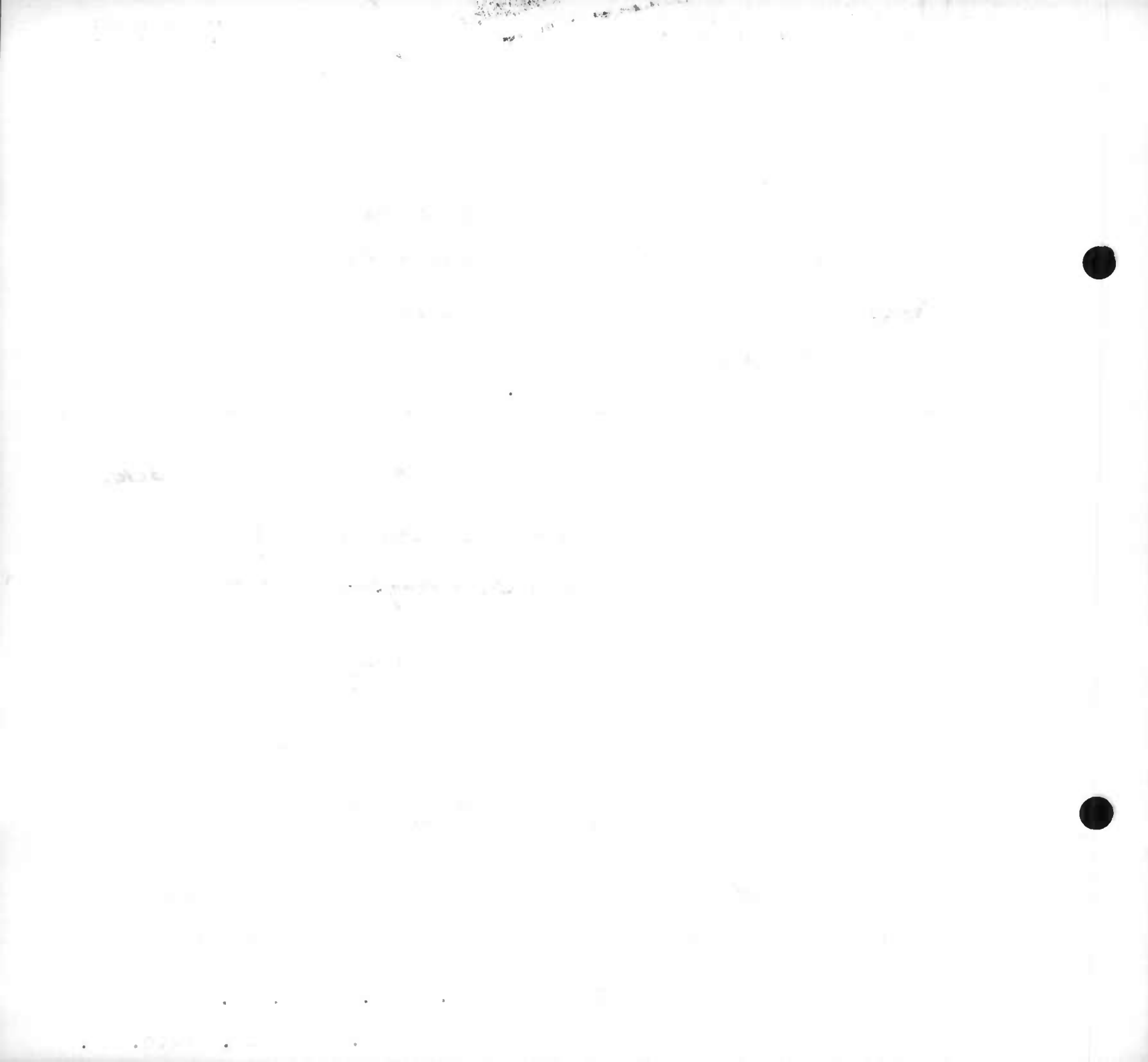
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 12791</span>	
K-432 70 12791				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">LORETTA KLOTZ BAUGH</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">12/31/70 1:20 PM</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">33</span> <span style="font-size: 1.2em;">The Johns Hopkins Hospital</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.5em;">2731</span> <span style="font-size: 1.2em;">3411 Parkside Drive</span>		
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">7/2/03</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">67</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">New York</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">Frank Duscher</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Francis <del>Bealer</del> Bieler</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">219-10-7924</span>		17. INFORMANT <span style="font-size: 1.2em;">Mr. Ralph J. Klotzbaugh</span>	
18. <span style="font-size: 1.5em;">25091</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Lactic Acidosis</span> (B) <span style="font-size: 1.5em;">Diabetes</span> DUE TO, OR AS A CONSEQUENCE OF: (C) <span style="font-size: 1.5em;">Congestive heart failure, aortic stenosis</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">24 hrs</span> <span style="font-size: 1.2em;">16 yrs</span> <span style="font-size: 1.2em;">11 mos</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO: YES</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">12/28</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">12/31</span> 19 <span style="font-size: 1.2em;">70</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">12/31</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Douglas A. Greene, M.D.</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">12/31/70</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">DOUGLAS A. GREENE M.D.</span>				23D. ADDRESS <span style="font-size: 1.2em;">Johns Hopkins Hospital</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">1/4/71.</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Druid Ridge Cemetery</span>	
24D. LOCATION <span style="font-size: 1.2em;">Baltimore, Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 5 1971</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. [illegible]</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Leonard J. Ruck, Inc.</span>		25D. ADDRESS <span style="font-size: 1.2em;">Balto. Md. 21214</span>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>F-435</u> <u>70 12792</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 12792</u>	
1. NAME OF DECEASED <u>mae</u> (Type or Print) <u>MILDRED M. FELDHEIM</u>				2. DATE AND HOUR OF DEATH <u>12/31/70</u> <u>11:30</u> <u>A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNION MEMORIAL HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>			
5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXXX</u> <u>Housewife</u>				E. STREET AND NUMBER <u>4315 MARBLE HALL ROAD</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>LOUIS BIERMAN</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		14. MOTHER'S MAIDEN NAME <u>ELLA COLLINS</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>B.</u> <u>212-07-8208</u>		17. INFORMANT <u>MR WALTER FELDTHEIM</u> <u>SAH C</u>	
18. <u>153.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>BRONCHOPNEUMONIA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <u>INTERSTINAL OBSTRUCTIONS -</u> <u>3 yrs. post-resection sigmoid cancer</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>BRONCHOPNEUMONIA</u> (B) <u>INTERSTINAL OBSTRUCTIONS -</u> DUE TO, OR AS A CONSEQUENCE OF: <u>3 yrs. post-resection sigmoid cancer</u> (C) <u>3 yrs. post-resection sigmoid cancer</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>							
19A. DATE OF OPERATION <u>Dec 21 '70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>INTESTINAL OBSTRUCTION</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>NOV. 29 19 70</u> to <u>DEC. 31 19 70</u> that (I) (we) last saw the deceased alive on <u>Dec 21 19 70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Victoria C. Gallardo</u> DEGREE				23B. DATE SIGNED <u>12/31/70</u>		23C. PHYSICIAN'S NAME (Type) <u>VICTORIA C. GALLARDO</u> DEGREE	
23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/4/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Mem. Gdns. Balto. Md.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1971</u>		25B. NAME OF REGISTRAR <u>Leonard J. Ruck Inc.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u>		ADDRESS <u>BALTO. MD.</u>	



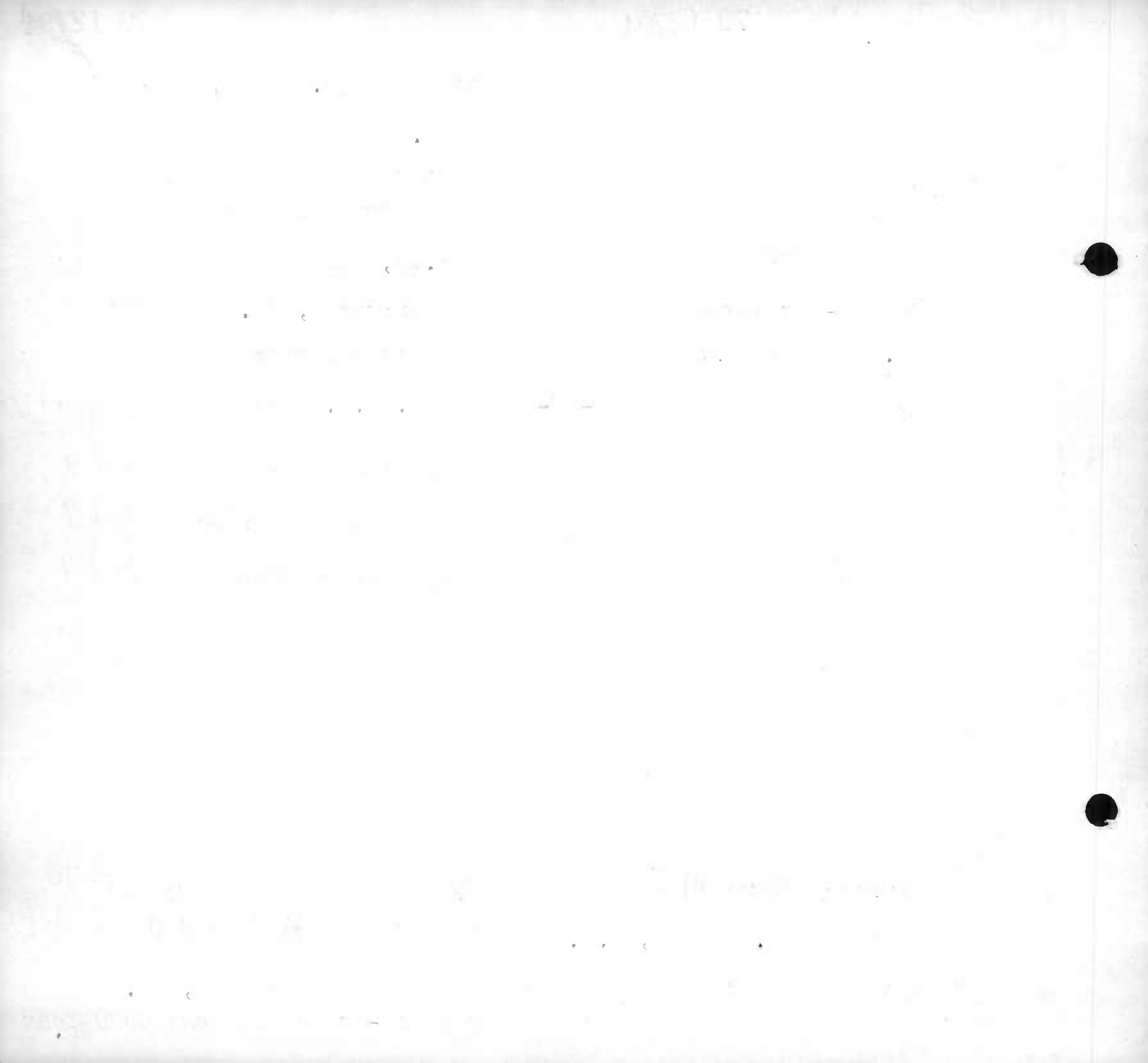
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>C-536</b>      <b>70 12793</b>      <b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p><b>70 12793</b></p> <p>REG. NO. _____</p>	
<p><b>BIRTH NO.</b></p> <p>1. NAME OF DECEASED (Type or Print)</p> <p style="text-align: center;"><u>Miss Ethel Canter</u></p>		<p>2. DATE AND HOUR OF DEATH</p> <p style="text-align: center;"><u>Dec. 25, 1970</u>      <u>12:15 P.M.</u></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p style="text-align: center;"><u>91 Keswick</u> <u>700 West 40th. Street</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE      B. COUNTY</p> <p style="text-align: center;"><u>Md.</u>      <u>Balto</u></p>	
<p>C. CITY OR TOWN</p> <p style="text-align: center;"><u>Balto.</u></p>		<p>D. INSIDE CITY LIMITS?</p> <p>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>E. STREET AND NUMBER</p> <p style="text-align: center;"><u>700 W. 40th St.</u></p>		<p style="font-size: 1.5em; font-weight: bold;">1307</p>	
<p>5. SEX</p> <p style="text-align: center;"><u>F</u></p>	<p>6. RACE</p> <p style="text-align: center;"><u>White</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH</p> <p style="text-align: center;"><u>Aug. 31, 1876</u></p>
<p>9. AGE (in years last birthday)</p> <p style="text-align: center;"><u>94</u></p>		<p>If Under 1 Yr. Months      Days</p>	<p>If Under 24 Hrs. Hours      Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p style="text-align: center;"><u>Housemother</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	
<p>11. BIRTHPLACE (State or foreign country)</p> <p style="text-align: center;"><u>Maryland</u></p>		<p>12. CITIZEN OF WHAT COUNTRY?</p> <p style="text-align: center;"><u>U.S.A.</u></p>	
<p>13. FATHER'S NAME</p> <p style="text-align: center;"><u>Isaiah Canter</u></p>		<p>14. MOTHER'S MAIDEN NAME</p> <p style="text-align: center;"><u>Mary E. Alney</u></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service</p> <p style="text-align: center;"><u>unknown</u>      <u>NO</u></p>		<p>16. SOCIAL SECURITY NO.</p> <p style="text-align: center;"><u>220-48-2130</u></p>	<p>17. INFORMANT</p> <p style="text-align: center;"><u>Keswick Records</u></p>
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;"><u>Arteriosclerotic CVD</u></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION</p> <p style="text-align: center;"><u>0</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p> <p style="text-align: center;"><u>NO</u></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> <p style="text-align: center;"><input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19<u>57</u> to <u>25 Dec</u> 19<u>70</u> that (I) (we) last saw the deceased alive on <u>25 Dec</u> 19<u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE</p> <p style="text-align: center;"><u>Harold P. Biehl, M.D.</u></p>		<p>23B. DATE SIGNED</p> <p style="text-align: center;"><u>12-25-70</u></p>	
<p>23C. PHYSICIAN'S NAME (Type)</p> <p style="text-align: center;"><u>Harold P. Biehl, M.D.</u></p>		<p>23D. ADDRESS</p> <p style="text-align: center;"><u>700 West 40th Street, Baltimore, MD. 21211</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p style="text-align: center;"><u>Burial</u></p>	<p>24B. DATE</p> <p style="text-align: center;"><u>12/29/70</u></p>	<p>24C. NAME OF CEMETERY or CREMATORY</p> <p style="text-align: center;"><u>All Faith Episcopal Cemt.</u></p>	<p>24D. LOCATION (City, town, or county) (State)</p> <p style="text-align: center;"><u>Charlotte Hall Md.</u></p>
<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p style="text-align: center;"><u>JAN 5 1971</u></p>		<p>25B. NAME OF REGISTRAR</p> <p style="text-align: center;"><u>Robert E. Taylor, M.D.</u></p>	
<p>25C. FUNERAL DIRECTOR</p> <p style="text-align: center;"><u>Mitchell Wiedefeld Home</u></p>		<p>ADDRESS</p> <p style="text-align: center;"><u>6500 York Rd.</u></p>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

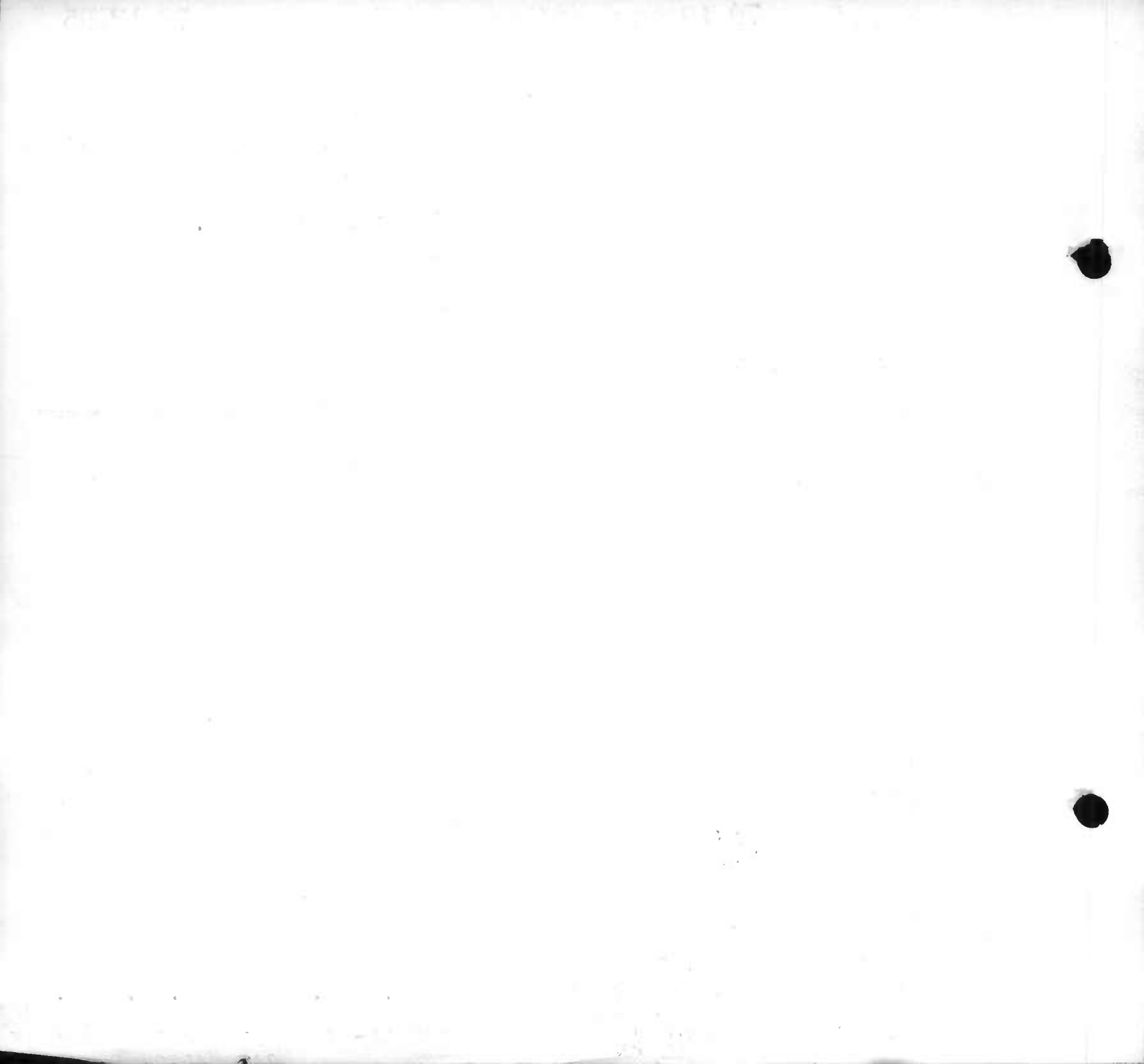
BALTIMORE CITY HEALTH DEPARTMENT						REG. NO.	70 12794
W-420		70 12794		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		MISS MADELINE HAYDON WELLS		DEC. 25, 1970		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  TYSON STREET				A. STATE Md.		8. COUNTY	
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 918 TYSON STREET		1102	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1911	9. AGE (In years last birthday) 59	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ARTIST-MUSICIAN			11. BIRTHPLACE (State or foreign country) BALTIMORE, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME J. BERNARD WELLS			14. MOTHER'S MAIDEN NAME ALICE HAYDON				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no at unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 220-12-6827		17. INFORMANT ADDRESS MRS. A.C. MOORE 208 CEDARCROFT RD		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  1. 41.01 CAUSE OF DEATH generalized cachexia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: generalized carcinoma metastases (B) DUE TO, OR AS A CONSEQUENCE OF: Carcinoma, base of tongue (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11-6-9 11-6-9 1-6-9			
<p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan. 12, 1969 to 12-25-70, that (I) (we) last saw the deceased alive on 12-25-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Alfred C. Moore M.D.				23B. DATE SIGNED 12-25-70			
23C. PHYSICIAN'S NAME (Type) ALFRED C. MOORE, M.D.				23D. ADDRESS 208 Cedarcroft Road, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/29/70		24C. NAME OF CEMETERY or CREMATORY DRUID RIDGE		24D. LOCATION (City, town, or county) (State) PIKESVILLE, MD.	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1971		25B. NAME OF REGISTRAR John E. Taylor, Jr.		25C. FUNERAL DIRECTOR MITCHELL-WIEDEFELD HOME		ADDRESS 6500 YORK RD.	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

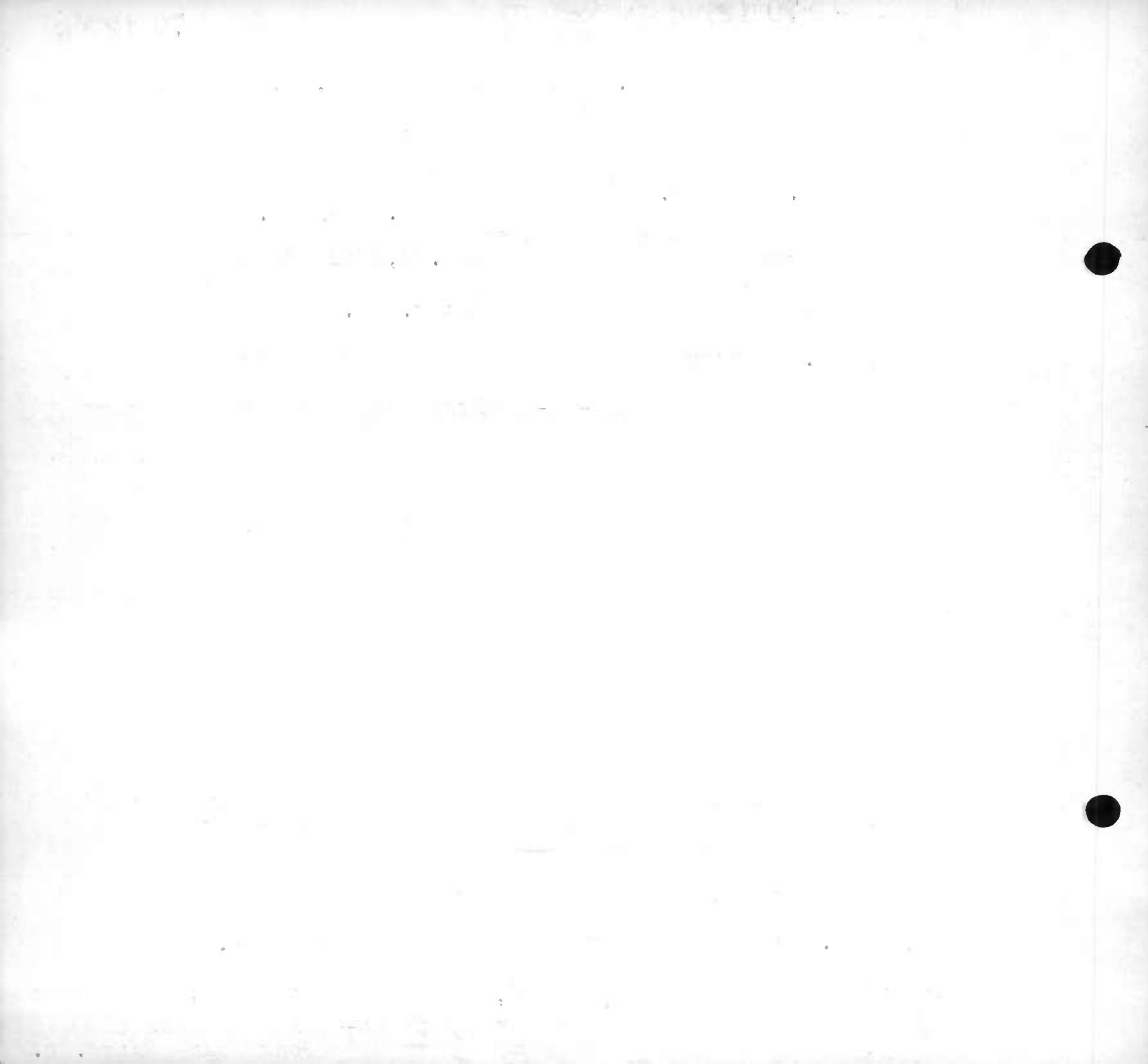
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 2em;">70 12795</span>	
BIRTH NO. <span style="font-size: 1.5em;">R-200</span>		NAME OF DECEASED <span style="font-size: 1.2em;">DAVID Richard Reese</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">2:15 PM 12/27/70</span>	
1. NAME OF DECEASED (Type or Print)		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">38 University of Maryland Hospital</span>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		A. STATE <span style="font-size: 1.2em;">XXXXXXXXXXXXXXXXXXXX MARYLAND</span>			
C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore Co</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <span style="font-size: 1.2em;">223 HIGH FALCON RD. 5300</span>					
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">12/14/70</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">13</span>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">CHILD</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">RICHARD PAUL REESE</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Catherine Richardson Reisterstown, Md</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">None</span>		17. INFORMANT <span style="font-size: 1.2em;">Hospital Record - PARENTS ABOVE</span>	
18. <span style="font-size: 1.2em;">74611</span>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Transposition of Great vessels</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">13 days</span>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">3 12/22/70</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">Transposition of great vessels</span>		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">Yes</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">DEC 20</span> 19 <span style="font-size: 1.2em;">70</span> to <span style="font-size: 1.2em;">DEC 27</span> 19 <span style="font-size: 1.2em;">70</span>		that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">DEC 27</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <span style="font-size: 1.2em;">R. Ashman, M.D.</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">12/27/70</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Ruth S. Ashman</span>	
23D. ADDRESS <span style="font-size: 1.2em;">University Hospital</span>		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <span style="font-size: 1.2em;">12/28/70</span>	
24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">DULANEY VALLEY MEM. GRDS.</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">BALTO. CO. MD.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 5 1971</span>	
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fisher, Jr.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">MITCHELL-WIEDEFELD HOME</span>		ADDRESS <span style="font-size: 1.2em;">6500 YORK ROAD BALTO. MD.</span>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

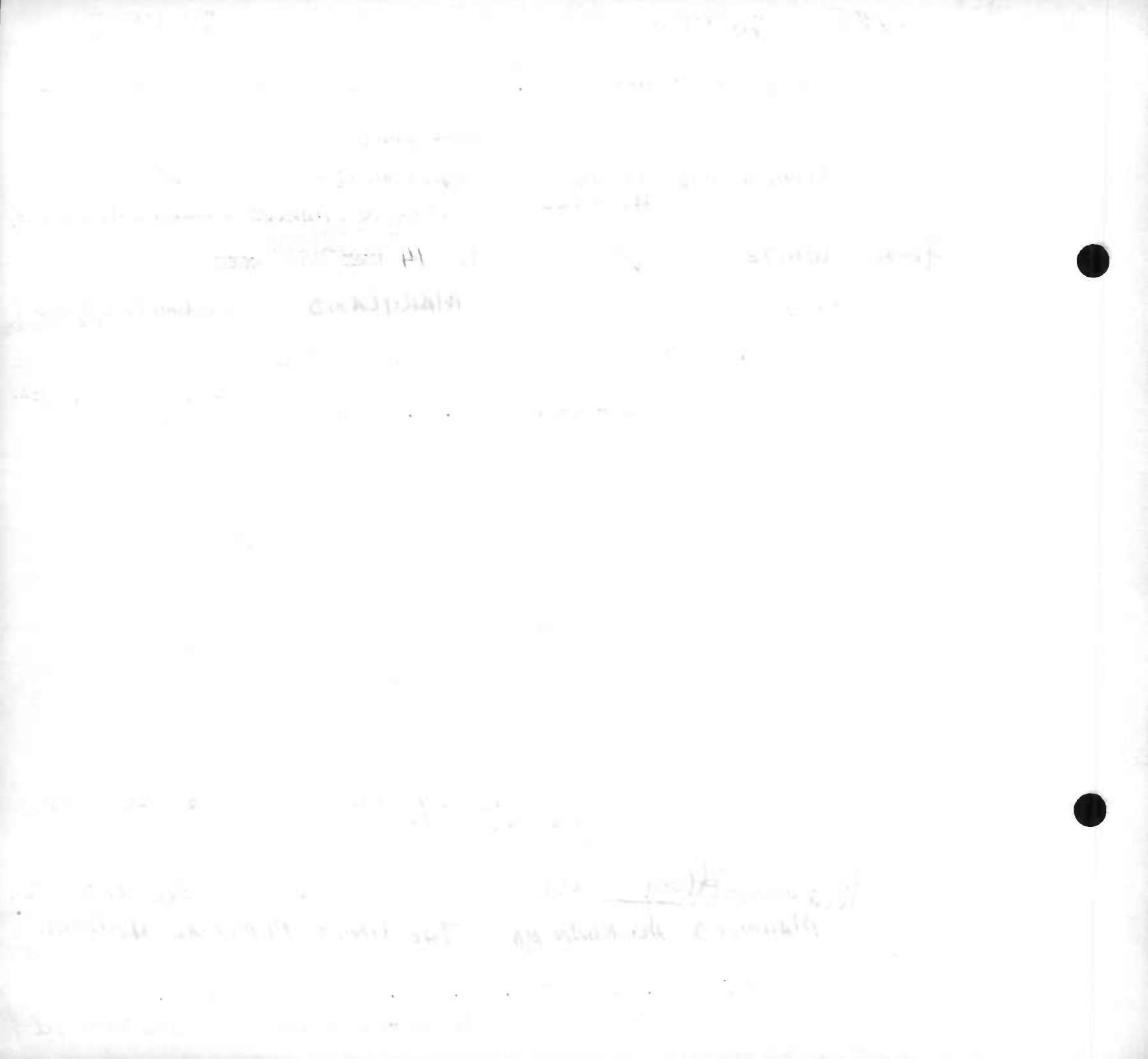
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12796	
M-265 70 12796				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Miss Mary C. McGrain		Dec. 27, 1970	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
435 E. 25TH St.			MARYLAND		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			435 E. 25TH St. 1203		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	SEPT. 14, 1891	79	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
BOOKEEPER				BALTO. MD.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
THOMAS J. McGRAIN			MARY TANYAE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		217-01-6566		Miss Nancy McGrain	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Acute coronary thrombosis		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST.			Arteriosclerotic heart disease		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			Disbiter mellitus		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from October 1957 to December 27, 1970, that (I) (we) last saw the deceased alive on December 17, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. Marion Friedman				12/28/70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
DR. MARION FRIEDMAN		5211 HARFORD RD.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL	12/30/70	CATHEDRAL CEMETERY		BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 5 1971		Robert E. Taylor, M.D.		MITCHELL-WIEDEFELD HOME 6500 YORK ROAD BALTO. MD.	



# FUNERAL DIRECTOR: IMPORTANT

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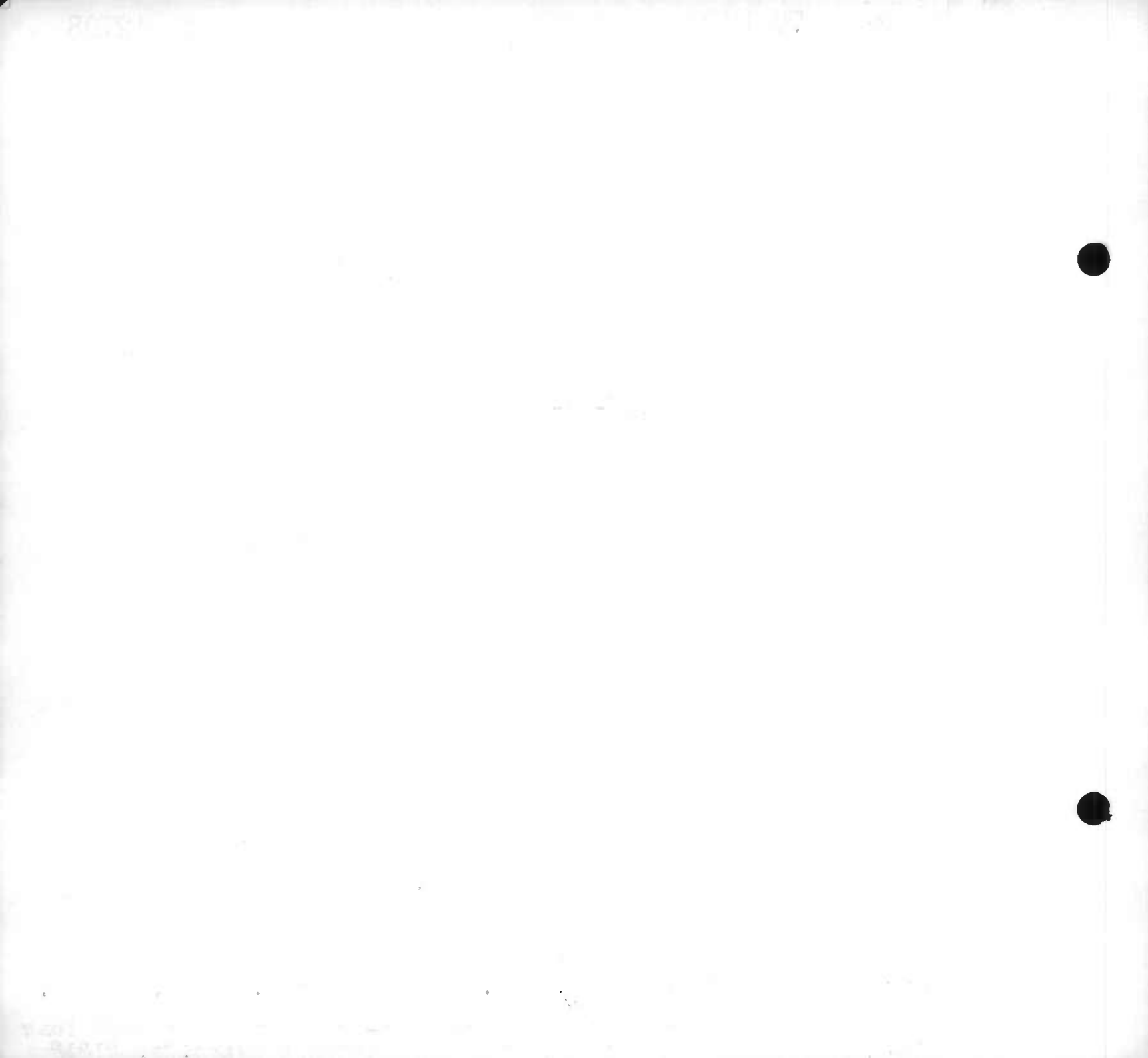
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12797	
W-425 70 12797		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WILSON ANNE H.</b>		2. DATE AND HOUR OF DEATH <b>Dec. 28th 1970 2.45 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSPITAL.</b>		C. CITY OR TOWN <b>BALTIMORE.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>3333 N. CHARLES, CHARLES APARTMENT.</b>		<b>1202</b>	
5. SEX <b>FEMALE.</b>	6. RACE <b>WHITE.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10. 14. 1908</b>	9. AGE (In years last birthday) <b>62</b>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND, Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES OF AMERICA</b>		13. FATHER'S NAME <b>Robert L. Hopkins</b>		14. MOTHER'S MAIDEN NAME <b>Susan Fitchett</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-44-4706</b>		17. INFORMANT <b>Welshire, Wilmington, Del</b> <b>Geo. L. Fosque 1205 Chadwick Rd</b>	
18. CAUSE OF DEATH <b>412.21</b>		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE: Cardiac Stand Still (asystole)</b> <b>(B) Post Cardiac arrest Sec. to ASCVD Hypertensive Heart Disease</b> <b>(C) Congestive Heart Failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Extreme Myocardial Excitability</b>		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12. 27. 1970</b> to <b>12. 28. 1970</b> that (I) (we) last saw the deceased alive on <b>12. 28. 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Mahmood Ali Khan MD</b>		23B. DATE SIGNED <b>Dec. 28th 1970</b>			
23C. PHYSICIAN'S NAME (Type) <b>MAHMOOD ALI KHAN MD</b>		23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/30/70</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Marys Epis. Ch. Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Emmorton, Md.</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>JAN 5 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>	
25C. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b>		25D. ADDRESS <b>6500 York Rd.</b>			



# FUNERAL DIRECTOR: IMPORTANT

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<div style="display: flex; justify-content: space-between;"> <span><b>F-140</b></span> <span><b>70 12798</b></span> </div>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		REG. NO. <b>70 12798</b>	
1. NAME OF DECEASED (Type or Print) <b>FOWBLE, George V.</b>		2. DATE AND HOUR OF DEATH <b>December 26, 1970 4.50 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Union Memorial Hospital 33rd and Calvert streets          44 Baltimore Maryland 21218.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-12</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital 33rd and Calvert streets          44 Baltimore Maryland 21218.</b>		C. CITY OR TOWN <b>City of Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>male</b> 6. RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>03-26-84</b> 9. AGE (in years last birthday) <b>86</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>American</b>		13. FATHER'S NAME <b>Mr. John FOWBLE.</b>			
14. MOTHER'S MAIDEN NAME <b>Mrs. Ellen FOWBLE. TOBY</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>217-03-9323</b>		17. INFORMANT <b>medical records Union Memorial Hospital          33rd and Calvert streets Baltimore Md 21218</b>			
18. <b>540.01</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac Arrest.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Ruptured Appendix.</b> DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-18-1970</b> to <b>12-26-1970</b> that (I) (we) last saw the deceased alive on <b>12-25-1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Fatih Salih Zada, M.D.</b>		23B. DATE SIGNED <b>26 Dec 70 at 5 A.M.</b>		23C. PHYSICIAN'S NAME (Type) <b>FATIH SALIH ZADA.</b>	
23D. ADDRESS <b>Union Memorial Hospital 33rd and Calvert streets          Baltimore Md 21218.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			
24B. DATE <b>12/29/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. COUNTY, MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1971</b>		25B. NAME OF REGISTRAR <b>Blaise J. ...</b>		25C. FUNERAL DIRECTOR <b>MITCHELL-WIEDEFELD HOME 6500 YORK</b>	
VS 150-REV. 1/1/68		ADDRESS <b>BALTO. COUNTY, MD. 21212</b>			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12799	
W-300 70 12799				CERTIFICATE OF DEATH	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Gertrude White				12/15/70 10:40 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mercy Hospital, Inc.				A. STATE Md. Baltimore Co	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER Dulaney Valley Rd.	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/13/83	9. AGE (In years last birthday) 87	10. UNDER 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			11. BIRTHPLACE (State or foreign country) Charleston S. Carolina		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Wm. McGrath			14. MOTHER'S MAIDEN NAME Mary Kanapaux		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 217485810		
17. INFORMANT Mrs Mary De Wald			ADDRESS 129 Murdock Rd.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RUPTURED ABDOMINAL ARTERY ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH acute	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1 1968 to Dec 15 1970 that (I) (we) last saw the deceased alive on Dec 15 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED 12-15-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS 301 St. Paul St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/19/70		24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	
				24D. LOCATION (City, town, or county) (State) Yeadin Pa.	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home 6500 York Balto. Md.	



FUNERAL DIRECTOR: IMPORTANT

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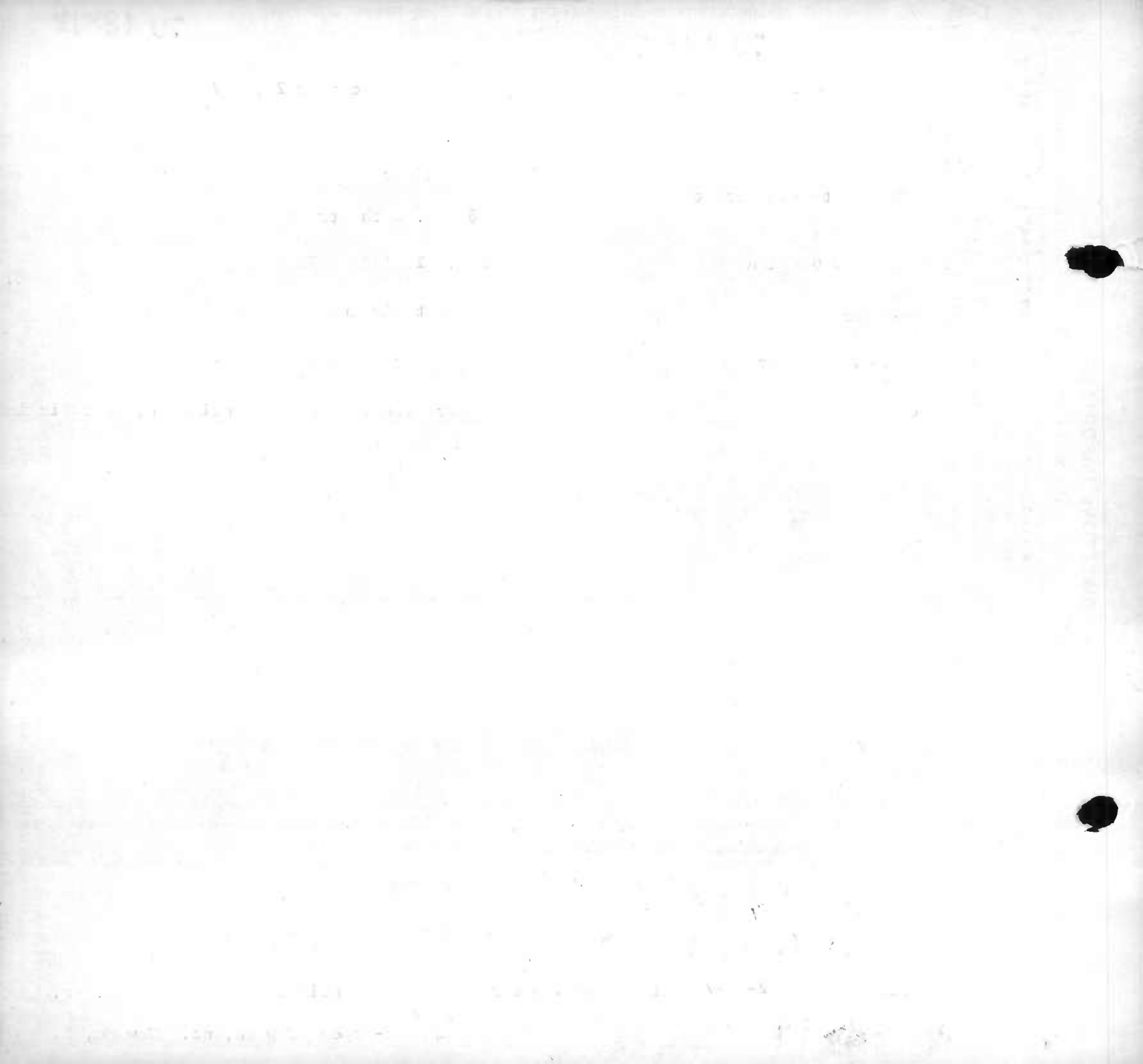
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>70 12800</b>	
<b>E-255 70 12800</b>		<b>CERTIFICATE OF DEATH</b>	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>MRS. ECKMANN, GRACE. W.</b>		<b>12.23.70</b>   <b>12.10 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 THE UNION MEMORIAL HOSPITAL.</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>TOWSON</b> <del>BALTIMORE</del>	
		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <b>502 Dogwood Lane.</b> <b>5300</b>	
5. SEX <b>Female</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10.06.03.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <b>67</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES OF AMERICA</b>	
13. FATHER'S NAME <b>MR. SIMON ZEPP.</b>		14. MOTHER'S MAIDEN NAME <del>UNKNOWN</del> <b>Catherine Behn</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-10-9483B</b>	
17. INFORMANT <b>MR. WARREN ECKMAN.</b>		502 Dogwood Rd ADDRESS	
18. <b>410.9 I</b> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF:	
[This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.]		(B) <b>Arteriosclerotic cardiovascular dis.</b> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		(C) <b>Int / TP</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinitely medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11.20</b> 19 <b>70</b> to <b>12.23</b> 19 <b>70</b> . that (I) (we) last saw the deceased alive on <b>12.23</b> 19 <b>70</b> , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Mahmood Ali Khan</b>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Mahmood Ali Khan M.D.</b>		23D. ADDRESS <b>Union Memorial Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/26/70</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>JAN 5 1971</b>		25B. NAME OF REGISTRAR <b>Rebecca</b>	
25C. FUNERAL DIRECTOR <b>Mitchell Wiedefeld</b>		ADDRESS <b>6500 Rock</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

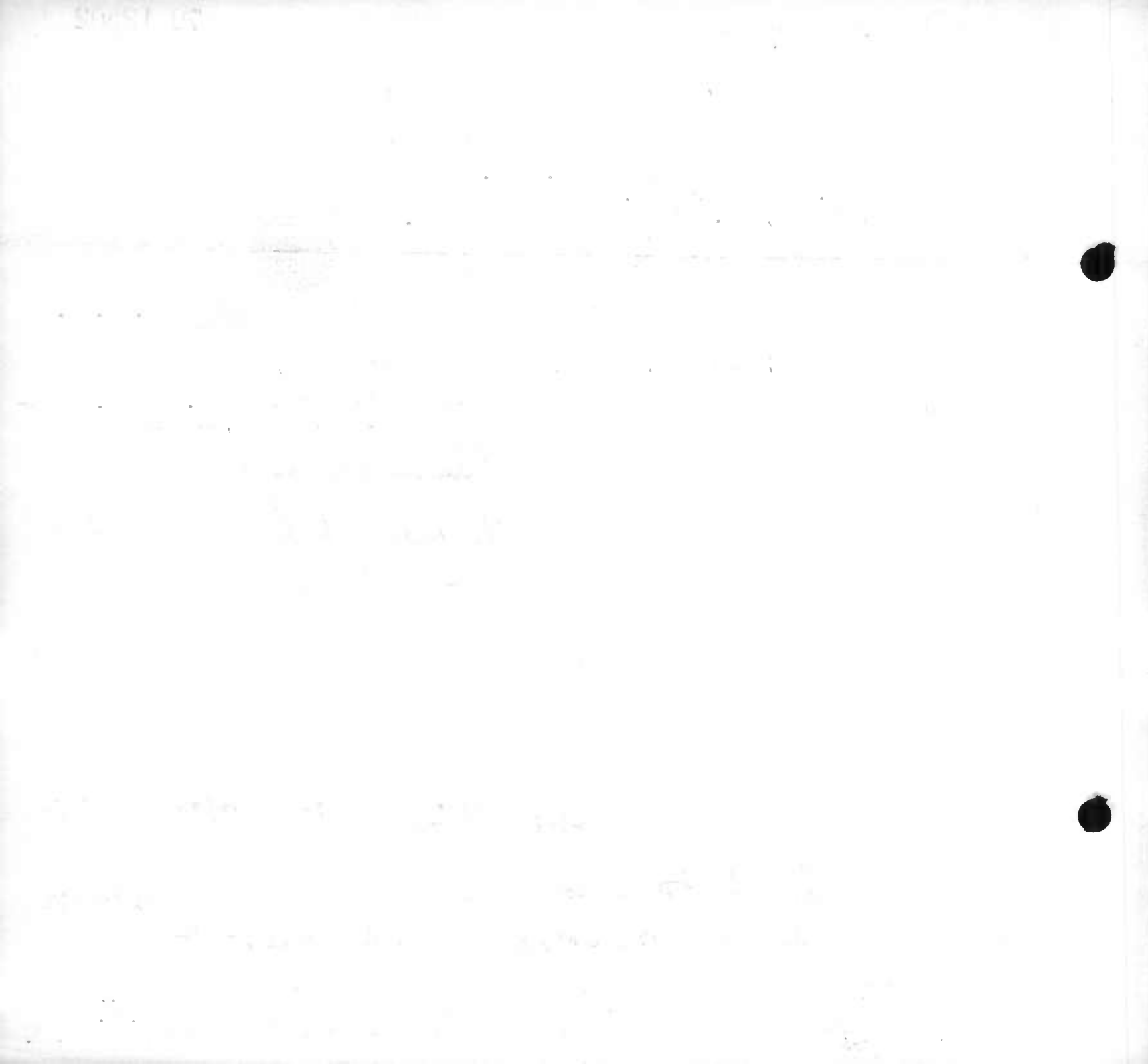
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 12801</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">H-200</span> <span style="font-size: 1.5em;">70 12801</span> <span style="font-size: 1.5em;">70 12801</span> </div>					
BIRTH NO. <span style="font-size: 1.5em;">70 12801</span>					
1. NAME OF DECEASED (Type or Print) <b>FRANCES SAUNDERS HOGG</b>			2. DATE AND HOUR OF DEATH <b>December 28, 1970</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>611 East 36th Street</b>			C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>Female</b>			6. RACE <b>Caucasian</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			8. DATE OF BIRTH <b>Jan. 12, 1905</b> 9. AGE (In years last birthday) <b>65</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John Saunders</b>			14. MOTHER'S MAIDEN NAME <b>Mary Malcolm</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Beard Funeral Home</b>			ADDRESS <b>Huntington, West Virginia</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>myocardial infarction</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Few minutes to an hour</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hypertensive C.V.D.</b>			<b>5 years</b>		
(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Diabetes Mellitus</b>			<b>5 years</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 19 53</b> to <b>Dec 28 19 70</b> , that (I) (we) last saw the deceased alive on <b>Dec 10 19 70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <b>Louis E. Wice M.D.</b>				23B. DATE SIGNED <b>12/29/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Louis E. WICE M.D.</b>				23D. ADDRESS <b>920 ST. PAUL ST.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-31-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Ridgeland Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Huntington</b>		(State) <b>W. Va.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1971</b>		25B. NAME OF REGISTRAR <b>John E. Cook</b>		25C. FUNERAL DIRECTOR <b>Wm., Cook-Brooks</b>	
Towson, Md.		Towson, Md.		Towson, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0216 70 12802		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 70 12802	
BIRTH NO. 0216			1. NAME OF DECEASED (Type or Print) <b>OSBOURNE, MARY</b>		
2. DATE AND HOUR OF DEATH <b>7:30 AM 12/30/70</b>			3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Bolton Hill Nursing &amp; Conv. Ctr.          140 W. Lafayette Ave.          Baltimore, Md. 21217</b>		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>Female</b>			6. RACE <b>White</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>8/7/18</b>		
9. AGE (In years lost birthday) <b>52</b>			10. UNDER 1 Yr. Months <b>11</b> Under 1 Yr. Days <b>18</b> Under 24 Hrs. Min. <b>03</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Williams, H. Viands</b>			14. MOTHER'S MAIDEN NAME <b>Longbeam, Mary</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>?</b>		
17. INFORMANT <b>Bolton Hill Nursing Ctr. 140 W. Lafayette Ave. Baltimore, 21217</b>			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Cervix c</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Metastasis to Liver</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>AB.C.V. Disease</b>			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>lung - bronch.</b>		
(C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yr.</b> <b>2 yr.</b> <b>?</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/18</b> 19 <b>70</b> to <b>12/30</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>12/28</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Joseph S. Blum</b>				23B. DATE SIGNED <b>12/30/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOSEPH S. BLUM MD</b>				23D. ADDRESS <b>1115 N. CALVERT ST</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/4/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
24D. LOCATION <b>Arlington</b>		24E. STATE <b>Va.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1971</b>	
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Higinbotham Slack</b>		ADDRESS <b>Ellicott City, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant the body was released to the hospital by a medical examiner. Also, if the d shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; was D.O.A. at a hospital (except where the physician who pronounced death deceased prior to death); and (6) No physician was in regular attendance on written approval must be obtained before the remains are embalmed or final disposition is made.

THIS IS A FEMALE

W-635 70 12803		BALTIMORE CITY HEALTH DEPARTMENT		70 12803	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) Worthington, Clarence			2. DATE AND HOUR OF DEATH 12/29/70 7:45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital Complex 2600 Liberty Heights Ave. Baltimore, Maryland 21215			A. STATE Maryland B. COUNTY Baltimore		
5. SEX Female			6. RACE Black		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 12-22-1875
Floor Lady - Candy Factory			Harford Co, Maryland		9. AGE (In years last birthday) 95
13. FATHER'S NAME Joseph Worthington			14. MOTHER'S MAIDEN NAME Olivia Johnson Worthington		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 215-10-2002		17. INFORMANT ADDRESS Lutherville, Md
18. CAUSE OF DEATH			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Arrest		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF: Acute Inferior wall MI		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/29/70 to 12/29/70		that (I) (we) last saw the deceased alive on 12/29/70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)
V. ACIDIO MD			Dec. 30, 1970		23D. ADDRESS
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME of CEMETERY or CREMATORY
Burial			1-2-1971		Angel Hill Cemetery
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR
JAN 5 1971			Robert E. Taylor, MD		Armocost Funeral Chapel-4600 Liberty Hts



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO.	
70 12804				70 12804	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Rausch, Betty Jean</u>				12/30/70 2:45P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hospital</u> 4940 Eastern Ave. Balto. Md. 21224				A. STATE <u>Maryland</u>	
				C. CITY OR TOWN <u>Baltimore</u>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>816 S. Robinson St. 21224 007</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-28-29</u>	9. AGE (in years last birthday) <u>41</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <u>Cleveland, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10B. KIND OF BUSINESS OR INDUSTRY <u>Dales Food Co.</u>			14. MOTHER'S MAIDEN NAME <u>Mildred Fifer</u>		
13. FATHER'S NAME <u>Richard Foulke</u>			17. INFORMANT <u>BCH-Records</u> ADDRESS <u>4940 Eastern Ave. Baltimore, Md. 21224</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>220-20-4235</u>		
18. <u>400.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Subarachnoid Hemorrhage</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24hrs</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Malignant Hypertension</u>			(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) _____			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Lyle Leibrock MD.</u> DEGREE				23B. DATE SIGNED <u>12-30-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>LYLE LEIBROCK</u> MD. DEGREE				23D. ADDRESS <u>4940 Eastern Ave. BCH- Baltimore, Md. 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/2/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		24E. STATE (State) _____		24F. _____	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>John A. Moran, Inc.-3000 E. Baltimore</u>	

1871 April 1st

1871 April 1st

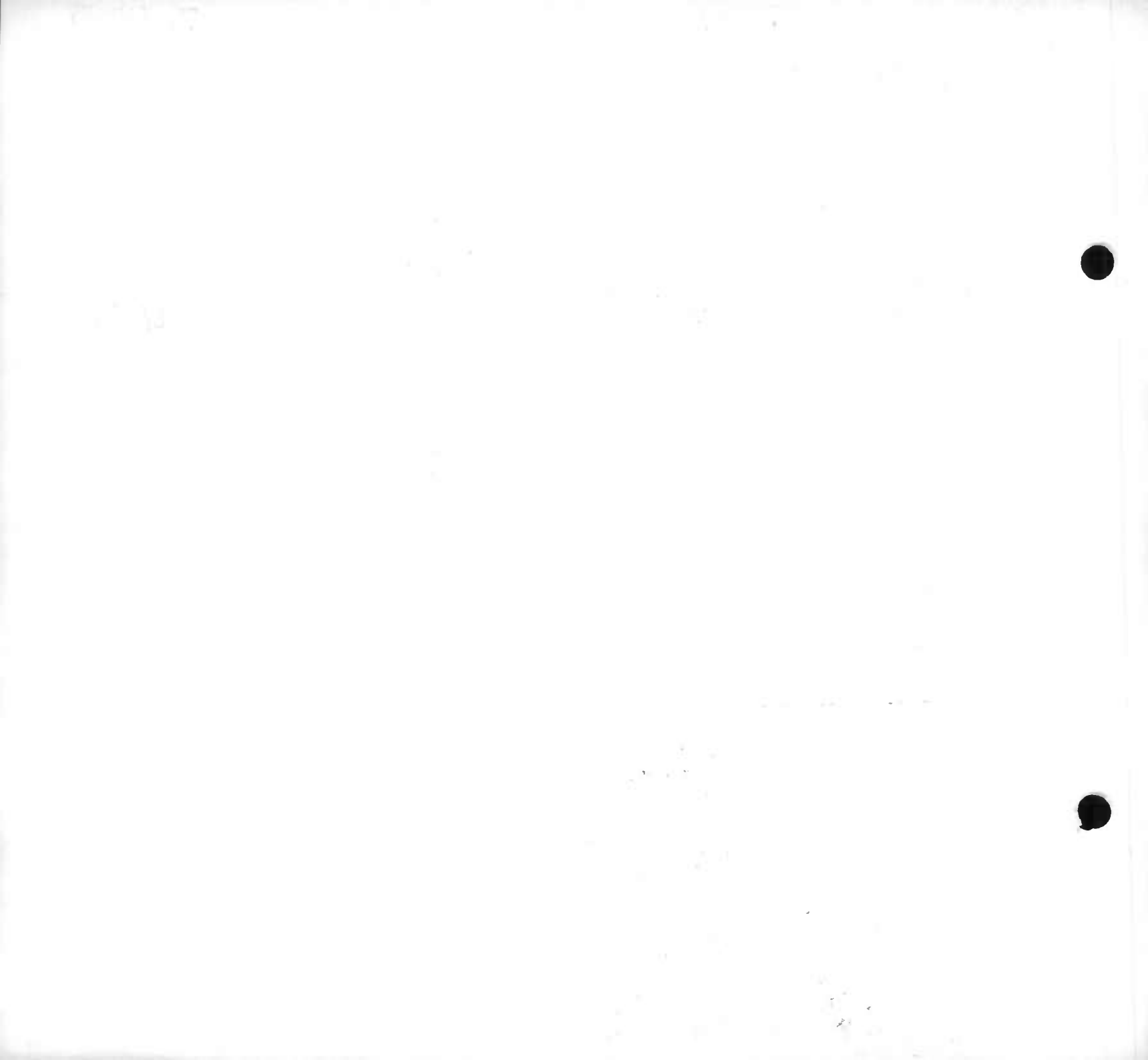
1871 April 1st

1871 April 1st

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 12805	
W-452 70 12805				70 12805	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED <i>MARIE Williams</i>			2. DATE AND HOUR OF DEATH <i>12/31/70 7:40 A.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, II institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Harbor View NCC</i>			A. STATE <i>MD.</i> B. COUNTY <i>BROOKLYN PK. AA</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <i>BROOKLYN PK.</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <i>F</i>			6. RACE <i>W</i>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <i>8/12/10</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sales Lady</i>			9. AGE (In years last birthday) <i>60</i>		
10B. KIND OF BUSINESS OR INDUSTRY <i>Whol Shoe Co.</i>			11. BIRTHPLACE (State or foreign country) <i>PA.</i>		
13. FATHER'S NAME <i>John W. Wagner</i>			14. MOTHER'S MAIDEN NAME <i>ANNA Lennhart</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>429-10-1059</i>		
17. INFORMANT <i>Husband</i>			ADDRESS <i>same</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Ca 1 Surg.</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION <i>12/21/70</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>12/30</i> 19 <i>70</i> to <i>12/31</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>12/31</i> 19 <i>70</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Anthony D. Sabundano, M.D.</i>			23B. DATE SIGNED <i>12-31-70</i>		
23C. PHYSICIAN'S NAME (Type) <i>A. SABUNDANO M.D.</i>			23D. ADDRESS <i>Harbor View NCC</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>B</i>			24B. DATE <i>1/4/71</i>		
24C. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 5 1971</i>			25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		
25C. FUNERAL DIRECTOR <i>W. E. City - 237</i>			ADDRESS <i>Tatasee</i>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-400 70 12806				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12806	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) <i>Marie Louise Hull</i>				2. DATE AND HOUR OF DEATH <i>12/31/70 12:30 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>House In Pines Belair</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>837 Belair Rd 21206</i>		A. STATE & COUNTY <i>Balto. Maryland</i>		C. CITY OR TOWN <i>Baltimore</i>	
90				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <i>741 S. Potomac St. 101</i>	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4-3-1887</i>	9. AGE (In years last birthday) <i>83</i>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Herman Koehler</i>				14. MOTHER'S MAIDEN NAME <i>?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-46-7769</i>		17. INFORMANT ADDRESS <i>August E. Aull, Jr. 634 S. Kenwood Ave</i>			
18. <i>4-10-71</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>ACUTE MYOCARDIAL INFARCTION</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>ARTERIOSCLEROSIS</i>			
(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Melito M. Torres, MD</i>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>12-31-70</i>	
23C. PHYSICIAN'S NAME (Type) <i>MELITO M. TORRES, MD</i>		23D. ADDRESS <i>BALTIMORE 24 441 S. ELLWOOD AVE.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>1-4-71</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn</i>		24D. LOCATION (City, town, or county) (State) <i>Balto Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 5 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Jones, Jr.</i>		25C. FUNERAL DIRECTOR <i>Thelma B. Hoffmann</i>		ADDRESS <i>3218 Hudson St</i>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		70 12807		70 12807	
BIRTH NO.		REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>FRANK WARD</b>		2. DATE AND HOUR OF DEATH <b>12/31/70 3:45 PM M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hosp. of Baltimore</b>		A. STATE <b>MD</b>		B. COUNTY <b>Harford</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>3604 Malden Ave.</b>		F. ZIP CODE <b>1338</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/28/02</b>	
9. AGE (in years, last birthday) <b>68</b>		10. AGE (in years, last birthday) <b>68</b>		11. BIRTHPLACE (State or foreign country) <b>S. Carolina</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>James Ward</b>		14. MOTHER'S MAIDEN NAME <b>Donaldson</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>248-05-4453</b>		17. INFORMANT <b>Etta Ward - 3604 Malden Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary artery disease</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary artery disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerosis &amp; insufficiency</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerosis &amp; insufficiency</b>		<b>years</b>	
(C) DUE TO, OR AS A CONSEQUENCE OF: <b>Probable rheumatic fever</b>				<b>years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>					
19A. DATE OF OPERATION <b>12/15/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Coronary artery disease</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. WHERE DID INJURY OCCUR? <b>Home</b>		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) <b>12/31/70</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Heart attack</b>	
22. I certify that (this hospital) attended the deceased from <b>12/15/70</b> to <b>12/31/70</b> that (we) last saw the deceased alive on <b>12/31/70</b> and that (my) (my) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did) view the body after death.					
23A. SIGNATURE <b>Alberto S. Barbedo, M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/31/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALBERTO S. BARBEDO, M.D.</b>		23D. ADDRESS <b>Sinai Hosp. of Baltimore</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/4/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>	
24D. LOCATION <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1971</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Donovan Funeral Home-3818 Roland Ave.</b>			

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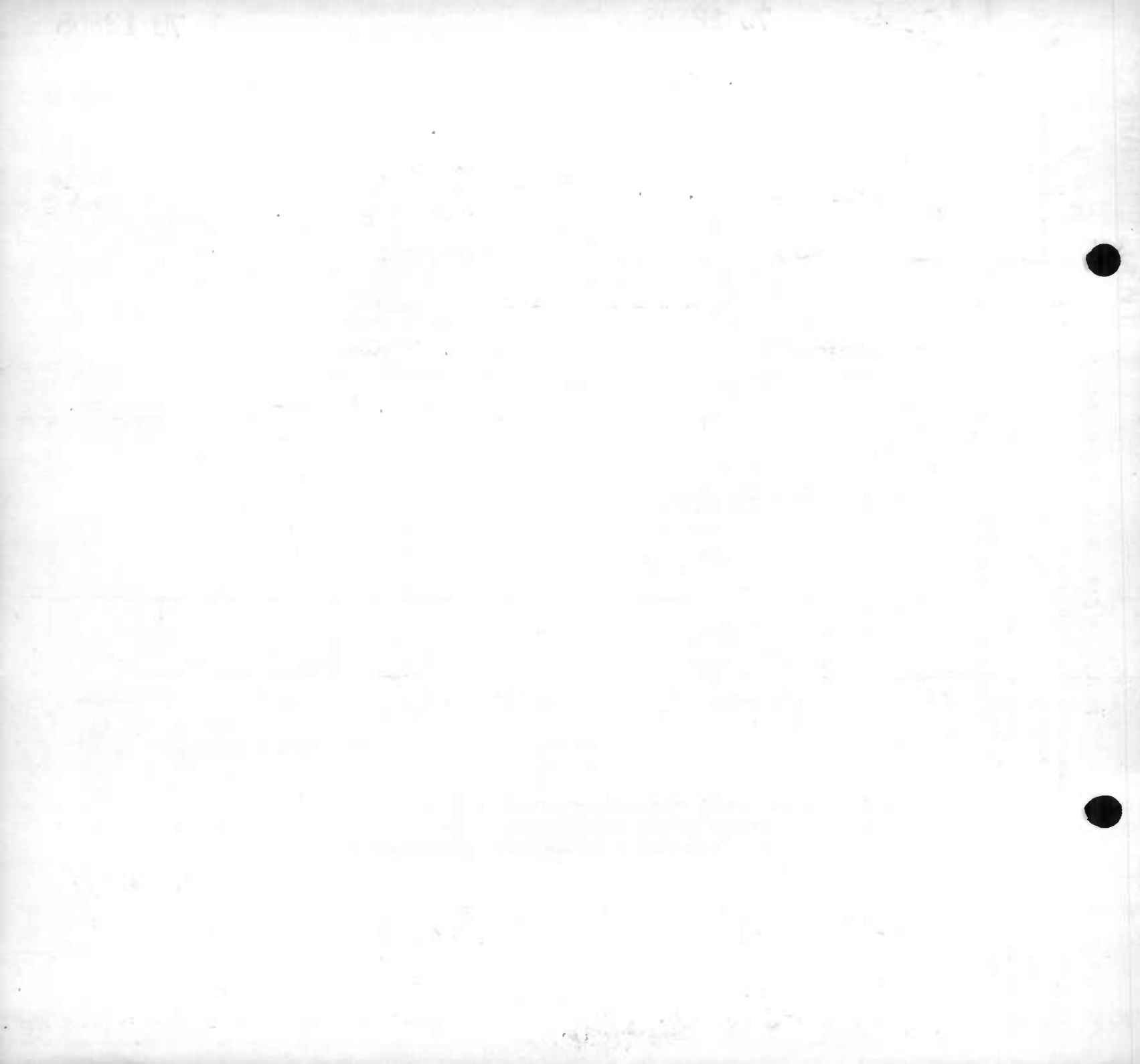
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 1.2em;">70 12808</span>
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">0-20</span>		<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Nellie M. O'Keefe</span>		
<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">December 31, 1970</span>		<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">1660 Darley Ave.</span>		
<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY _____		<b>5. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>6. DATE OF BIRTH</b> <span style="font-size: 1.2em;">8/15/1889</span> <b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">81</span>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Ireland</span> <b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>		
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Patrick Brennan</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">B. McHale</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		<b>16. SOCIAL SECURITY NO.</b> _____ <b>17. INFORMANT</b> <span style="font-size: 1.2em;">Thomas P. O'Keefe</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">-1106 Weldon Ave.</span>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		<b>CAUSE OF DEATH</b> <span style="font-size: 1.5em; font-family: cursive;">Arteriosclerotic Disease</span> <b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: _____  <b>(B)</b> _____ DUE TO, OR AS A CONSEQUENCE OF: _____  <b>(C)</b> _____		
<b>19A. DATE OF OPERATION</b> _____ <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> _____ <b>20A. AUTOPSY?</b> (Yes or No) _____ <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> _____		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/> <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) _____ <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____ <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <b>21F. HOW DID INJURY OCCUR?</b> _____		
<b>22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date _____ and hour _____ and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em; font-family: cursive;">Edward D. Hallen</span>		<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">1/2/71</span>		
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Edw. S. Kallins</span>		<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">6000 Park Hts Dr</span>		
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">1/4/71</span> <b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">New Cathedral Cemetery</span> <b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>		
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">JAN 5 1971</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Kelly</span> <b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Donovan Funeral Home</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">-3818 Roland Ave.</span>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

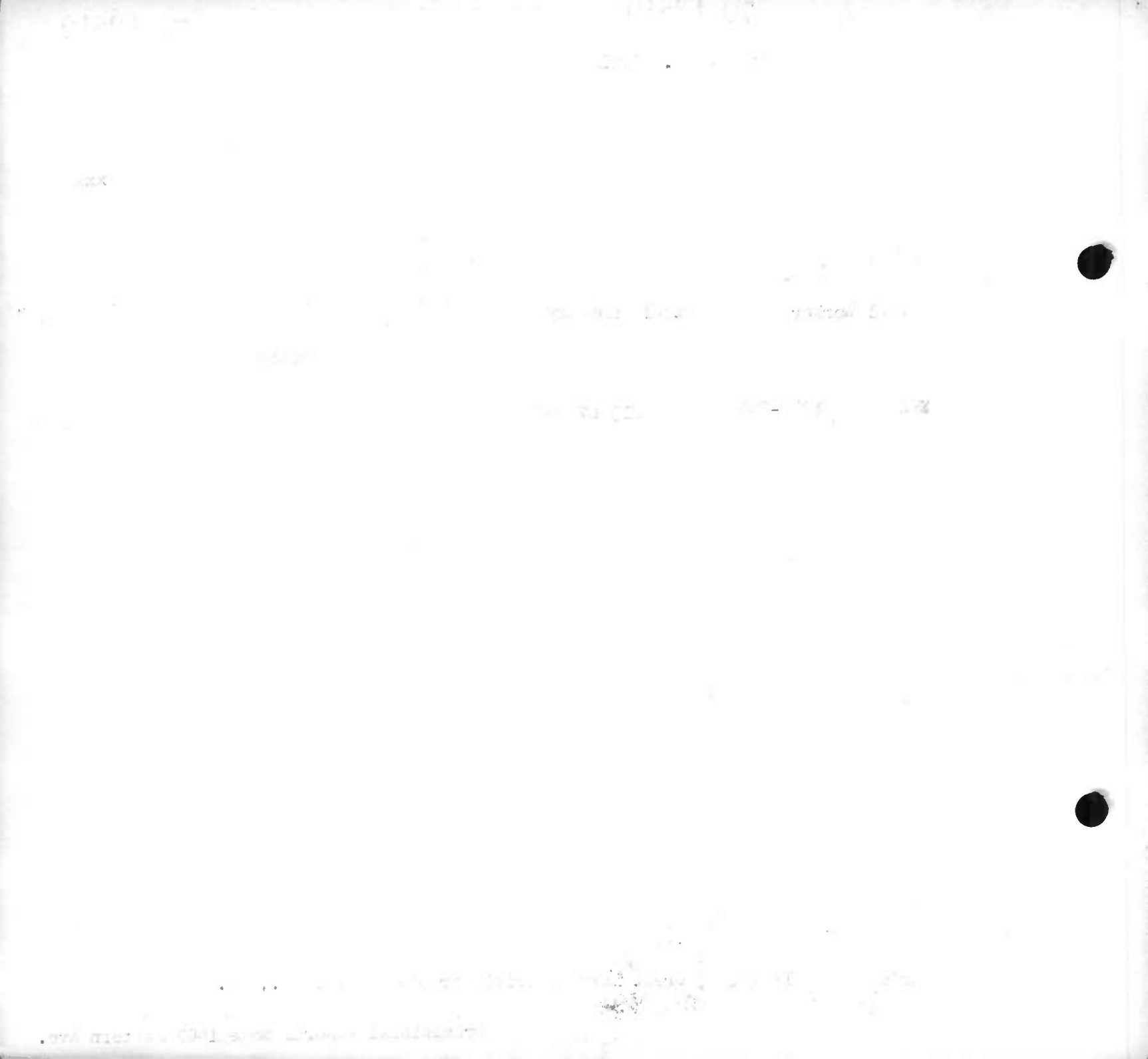
Baltimore City Health Department				REG. NO.	
J-650		70 12809		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
TARIN, Arthur			12/30/70 6:15 a. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
33 The Johns Hopkins Hospital			New Jersey Somerset		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Bound Brook		YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			225 Mountain Avenue		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6/15/08	62	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Morris Tarin			Ida Shapiro		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
			139-28-4657		Hospital Records
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			20 MIN.		
ANTECEDENT CAUSES			1 DAY		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			YEARS.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
12/29/70		MITRAL INCOMPET.	Yes		NO.
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?		
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from DEC 16 19 70 to DEC 30 19 70, that (1) (we) last saw the deceased alive on DEC 30 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
William E. Walker, M.D.			12/30/70		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
William E. Walker, M.D.			The Johns Hopkins Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Removal	12/30/70			Bound Brook, New Jersey	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 5 1971		Robert C. Altenburg		Robert C. Altenburg Funeral Home, Inc. 6009 Harford Rd. - Balto., Md. 21214	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

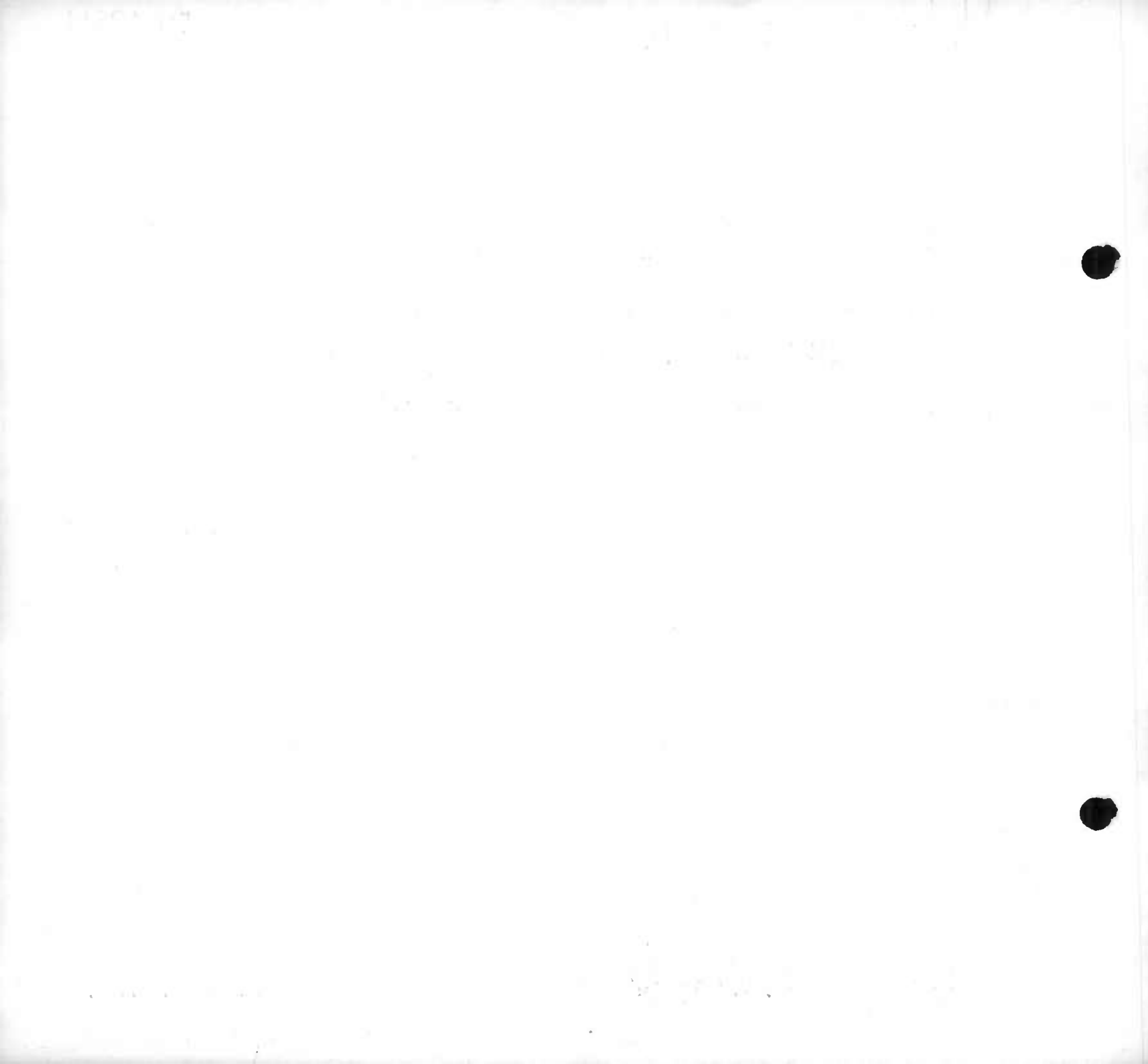
BIRTH NO. <u>M-240</u>				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12810</u>			
1. NAME OF DECEASED (Type or Print) <u>Stephen E. Migol</u>								2. DATE AND HOUR OF DEATH <u>11:55, 12-31-70</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD								4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Church Home &amp; Hospital 35 Baltimore MD. 21231 USA</u>								A. STATE <u>MD.</u> B. COUNTY <u>Baltimore Co.</u>			
								C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
								E. STREET AND NUMBER <u>618 E Franklin Ave 5300</u>			
5. SEX <u>Male</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-15-1904</u>		9. AGE (In years last birthday) <u>66 yrs</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Steel Industry</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John P Migol</u>								14. MOTHER'S MAIDEN NAME <u>Dora Smeton</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES 1927-30?</u>				16. SOCIAL SECURITY NO. <u>213 07 3992</u>		17. INFORMANT <u>Edward S Migol</u> ADDRESS <u>359 Decanne Rd 624</u>					
18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)								CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.								(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute mi</u> <u>Gr. nstic Septicemia</u>			
								(B) DUE TO, OR AS A CONSEQUENCE OF: <u>A SHD</u>			
								(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from <u>12-8-1970</u> to <u>12-31-1970</u> that (H) (we) last saw the deceased alive on <u>12-31-1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Abdus Samad MD</u>								Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12-31-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>ABDUS SAMAD MD</u>								23D. ADDRESS <u>Church Home &amp; Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>1/4/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Crest Lawn Memorial Gardens</u>				24D. LOCATION (City, town, or county) (State) <u>Howard Co., Md.</u> <u>(31)</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1971</u>				25B. NAME OF REGISTRAR <u>Reese</u>				25C. FUNERAL DIRECTOR <u>Bruzdzinski</u> ADDRESS <u>1407 Eastern Ave.</u>			



# FUNERAL DIRECTOR: IMPORTANT

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C-654		70 12811		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		70 12811	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Lottie Cornelius</b>				2. DATE AND HOUR OF DEATH <b>12-29-70 11:45 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN Hospital</b>						A. STATE <b>MD</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
						E. STREET AND NUMBER <b>4017 Liberty Hght Ave</b>		<b>1510</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-24-88</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown Charles W. Ebberts</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No None</b>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Family information</b>			
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary aspiration</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Congestive heart failure - HSCVD several years</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>12-12-70</b> to <b>12-29-70</b> that (I) (we) last saw the deceased alive on <b>12-29-70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Myung Duck Ro</b>						DEGREE		23B. DATE SIGNED <b>12-29-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Myung Duck Ro</b>						23D. ADDRESS <b>Lutheran hosp. 730 Ashburton st</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Dec. 31, 1970</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Zion Lutheran Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Middle River, Balto. Co., Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Md.</b>		25C. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>		ADDRESS			



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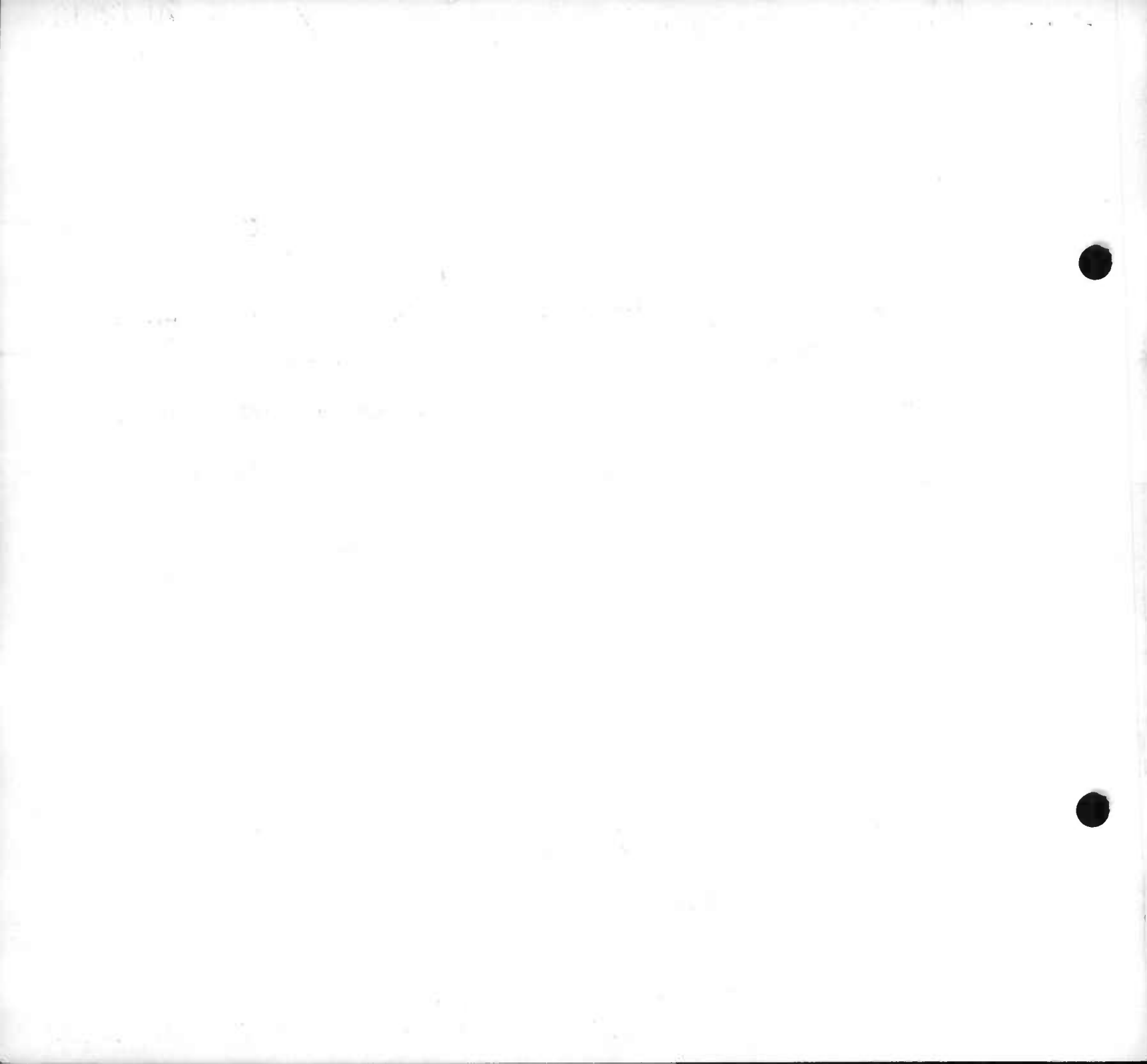
P-620 BIRTH NO.		70 12812		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 12812	
1. NAME OF DECEASED (Type or Print) <b>DOROTHY MAY PEREGOV</b>				2. DATE AND HOUR OF DEATH <b>DEC. 24 1970 2:50 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>22919 Alvarado Square</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
5. SEX <b>Female</b>				6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>May 12, 1884</b>		9. AGE (In years last birthday) <b>75</b>		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10. B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Alfred Charles Hawkins</b>				14. MOTHER'S MAIDEN NAME <b>Adelaide Cousins</b>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Daniel A. Peregov</b>			
18. <b>412.4 I</b>		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Vascular Accident</b>				6 hrs.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic Cardiovascular Disease</b>				5 yrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Parkinson Disease</b>				8 mo.			
19A. DATE OF OPERATION <b>June 19 70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>June 19 70</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>June 19 70</b> to <b>December 19 70</b> , that (I) (we) last saw the deceased alive on <b>Dec. 24 19 70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Clarence W. LeDoux</b>						23B. DATE SIGNED <b>12/28/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Clarence W. LeDoux, M.D.</b>				23D. ADDRESS <b>3023 Eastern Ave. Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Dec. 28, 1970</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Towson, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

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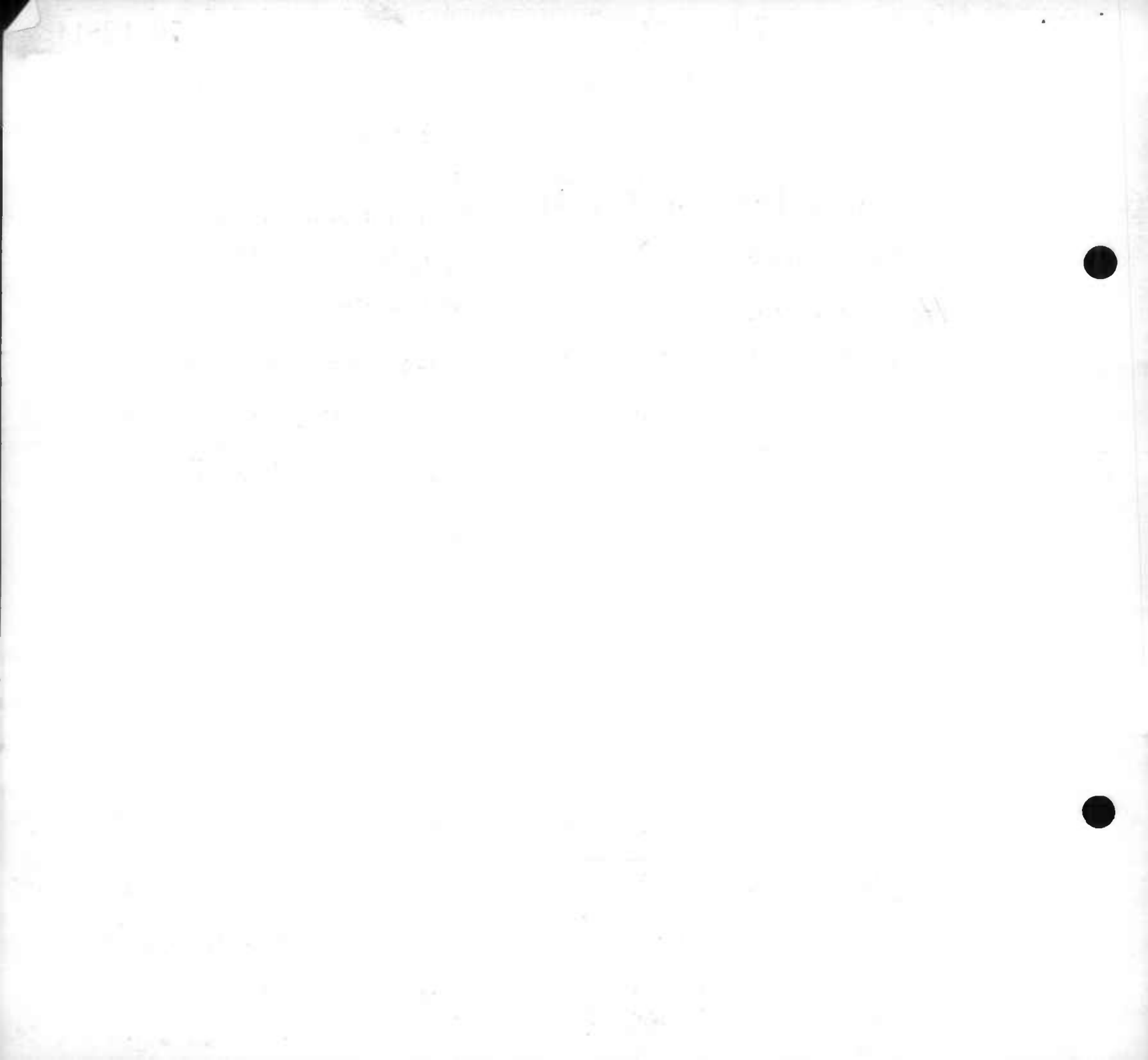
W-62-1		70 12813		BALTIMORE CITY HEALTH DEPARTMENT		X		70 12813	
BIRTH NO.		70 12813		CERTIFICATE OF DEATH		REG. NO.			
1. NAME OF DECEASED (Type in Print) ANIELA WURZBACHER				2. DATE AND HOUR OF DEATH Dec 28 1970 7:15 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BELAIR HOUSE IN PINES				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Balto C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1236 KNIGHTSWOOD Rd 21212					
5. SEX F		6. RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/17/82		9. AGE (In years last birthday) 88	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEN'S STRAW HAT Levy & Co.				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Conrad Wurtzbacher				14. MOTHER'S MAIDEN NAME Mary Seidel					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Lillian Goetze-1236 Knightswood Rd.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 12/22/70 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from July 1 1962 to Dec 28 1970 and that (I) (we) lost saw the deceased alive on 12/22/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE 23B. DATE SIGNED 23C. PHYSICIAN'S NAME (Type) 23D. ADDRESS 24A. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) (State) 25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS									
18. 4/12/31 Arteriosclerotic Heart Disease (A) IMMEDIATE CAUSE Due to, or as a consequence of: Cerebral arteriosclerosis - (B) Due to, or as a consequence of: Advanced degenerative disease (C) Kistler Hernia - Ch Anemia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
23A. DONALD W. MINTZER				23B. 12/28/70		23C. DONALD W. MINTZER		23D. 3009 EVERGREEN AVE BALTIMORE	
24A. Burial				24B. 12-31-70		24C. Immanuel Lutheran Cem.		24D. Balto. Md.	
25A. JAN 5 1971				25B. RALPH E. JELLY		25C. JOHN C. MILLER INC		25D. 6415 BELAIR RD. -21206	



# FUNERAL DIRECTOR: IMPORTANT

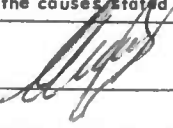
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

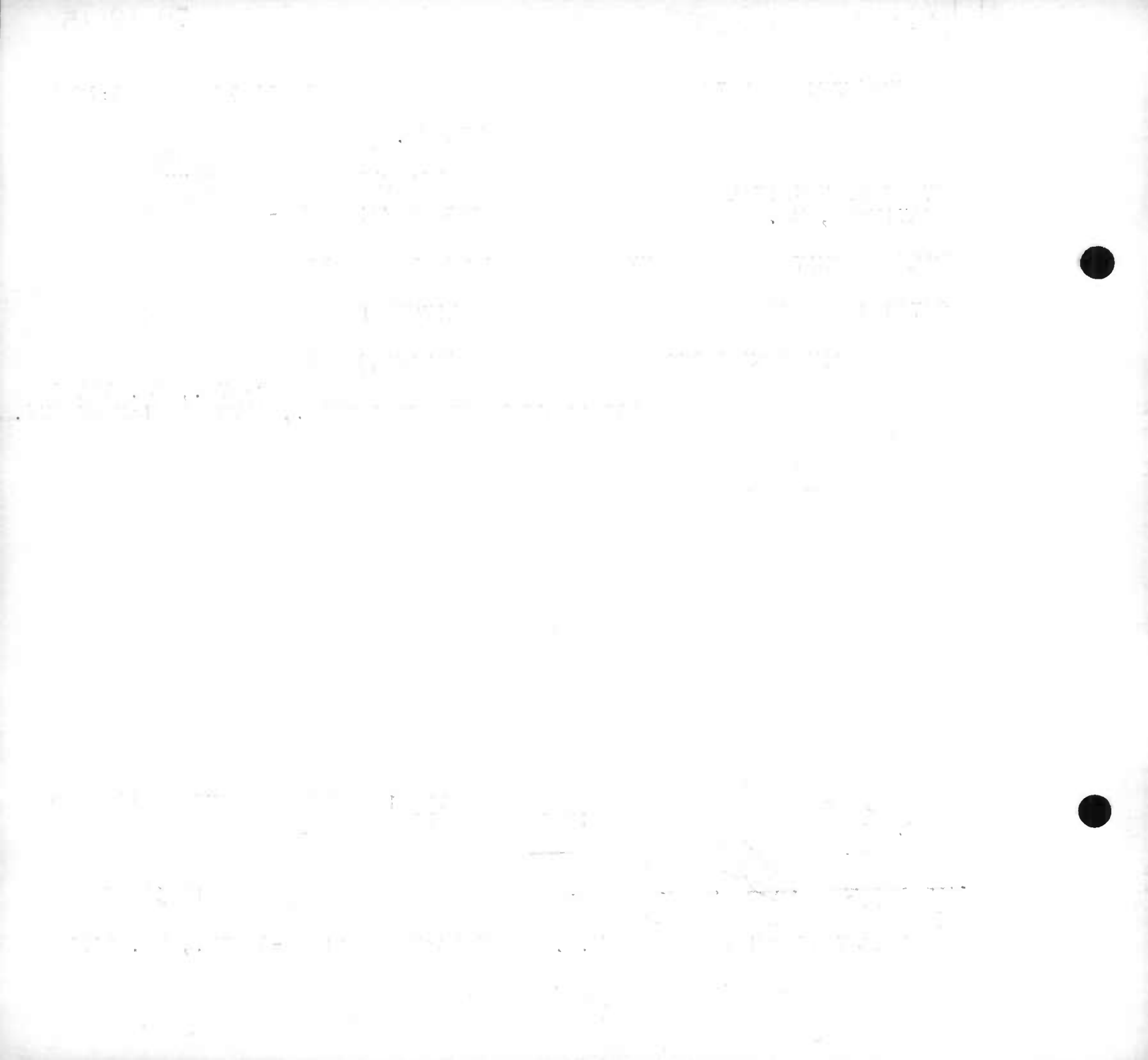
BIRTH NO. <span style="float: right;">H-252</span>		BALTIMORE CITY HEALTH DEPARTMENT 70 12814 CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">70 12814</span>	
1. NAME OF DECEASED (Type or Print) <b>Higgins KATHERINE</b>			2. DATE AND HOUR OF DEATH <b>December 28, 1970 5 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>44 UNION MEMORIAL Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY _____		
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL Hospital</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			E. STREET AND NUMBER <b>3131 RAVENWOOD AVE 841</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/4/98</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months _____ Days _____ If Under 24 Hrs. Hours _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home Maker</b>			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13. FATHER'S NAME <b>Martin L. Stackert</b>			14. MOTHER'S MAIDEN NAME <b>Louise Wiedeman</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service			16. SOCIAL SECURITY NO. <b>212-03-3001</b>		
			17. INFORMANT <b>Irvin F. Higgins - Same</b>		
18. <b>436191</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Cerebrovascular Accident</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>Dec 28 1970</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>December 28 1970</b> to <b>Dec 28 1970</b> that (I) (we) last saw the deceased alive on <b>December 28 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Miguel Karacuschansky M.D.</b>				23B. DATE SIGNED <b>December 28, 1970</b>	
23C. PHYSICIAN'S NAME (Type) <b>Miguel KARACUSCHANSKY M.D.</b>				23D. ADDRESS <b>UNION MEMORIAL Hospital</b>	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE <b>12/31/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Monkland Memorial</b>	
24D. LOCATION <b>Balto. Md</b>		24E. LOCATION <b>Balto. Md</b>		24F. LOCATION <b>Balto. Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1971</b>		25B. NAME OF REGISTRAR <b>John E. Miller, R.R.</b>		25C. FUNERAL DIRECTOR <b>John C. Miller Inc - 6415 Belair Rd.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>B-120</span> <span>70 12815</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		<div style="display: flex; justify-content: space-between;"> <span>REG. NO.</span> <span>70 12815</span> </div>	
1. NAME OF DECEASED (Type or Print) <b>BUBBOCKS PETER</b>		2. DATE AND HOUR OF DEATH <b>12 31 70 9:10 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST AGNES HOSPITAL BALTIMORE, MD.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY  C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5409 MAYVIEW AVE- 2641</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5 20 1893</b>
9. AGE (In years lost birthday) <b>78 77</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED PRESSER</b>	
11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>SIMON BUBBOCKS</b>		14. MOTHER'S MAIDEN NAME <b>(SLEMON) ANNA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213 20 5597</b>	
17. INFORMANT <b>BALTO., MD. 21229</b>		ADDRESS <b>ST AGNES HOSP., CATON &amp; WILKENS AVE.</b>	
18. <b>4 36.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Prob. Cerebro-Vascular Accident</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Artherosclerotic Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>acute Cholecystitis -</b>			
19A. DATE OF OPERATION <b>12 31 1970</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>12 31 1970</b> to <b>12 31 1970</b> that (we) lost saw the deceased alive on <b>12 31 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED <b>12 31 70</b>	
23C. PHYSICIAN'S NAME (Type) <b>SALVATORE QUIROZ M.D.</b>		23D. ADDRESS <b>ST AGNES HOSPITAL-BALTO., MD. 21229</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-4-1971</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>	
25C. FUNERAL DIRECTOR <b>Thomas J. Henry Inc</b>		ADDRESS <b>1600 Hollins St</b>	



A-516

70 12816

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12816

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Walter Ambrose		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12/26/70	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1206 Union Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 26 70 5:02 p. M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 3/ /99		10. AGE (in years last birthday) 71	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY ?	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 220-09-5013	
18. INFORMANT Lillie M. Ambrose		ADDRESS 4425 Grandview ave.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fatty alteration of liver DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/26/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/30/70	
24C. NAME OF CEMETERY or CREMATORY Poplar Grove		24D. LOCATION (City, town, or county) (State) Balto. Co.	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1977		25B. NAME OF REGISTRAR Paul E. Chenoweth Jr.	
25C. FUNERAL DIRECTOR 3617 Chestnut Ave.		ADDRESS	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 12817		REG. NO. 70 12817	
BIRTH NO. H-635				70 12817			
1. NAME OF DECEASED (Type or Print) Clara M. Horton				2. DATE AND HOUR OF DEATH 12/28/70 4 00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> FULL NAME OF DECEASED (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hosp. 1-7-71				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY Howard Co. 63-00			
5. SEX Female				6. RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6/28/70				9. AGE (In years last birthday) 77		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT James H. Horton 5610 Wash. Blvd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) cardiac failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: arteriosclerosis (B) heart disease (C) arterial hypertension ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 2 yrs 10 yrs			
19. DATE OF OPERATION				20. AUTOPSY? (Yes or No)			
21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				22. I certify that (1) (this hospital) attended the deceased from Jan 1970 to Dec 28 1970, that (1) (we) last saw the deceased alive on Dec 27 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE B. BRUCE BRUMBAUGH MD				23B. DATE SIGNED 12/30/70			
24. BURIAL CREMATION, REMOVAL (Specify) Burial				25. FUNERAL DIRECTOR Paul E. Chenoweth 3rd 3617 Chestnut A			

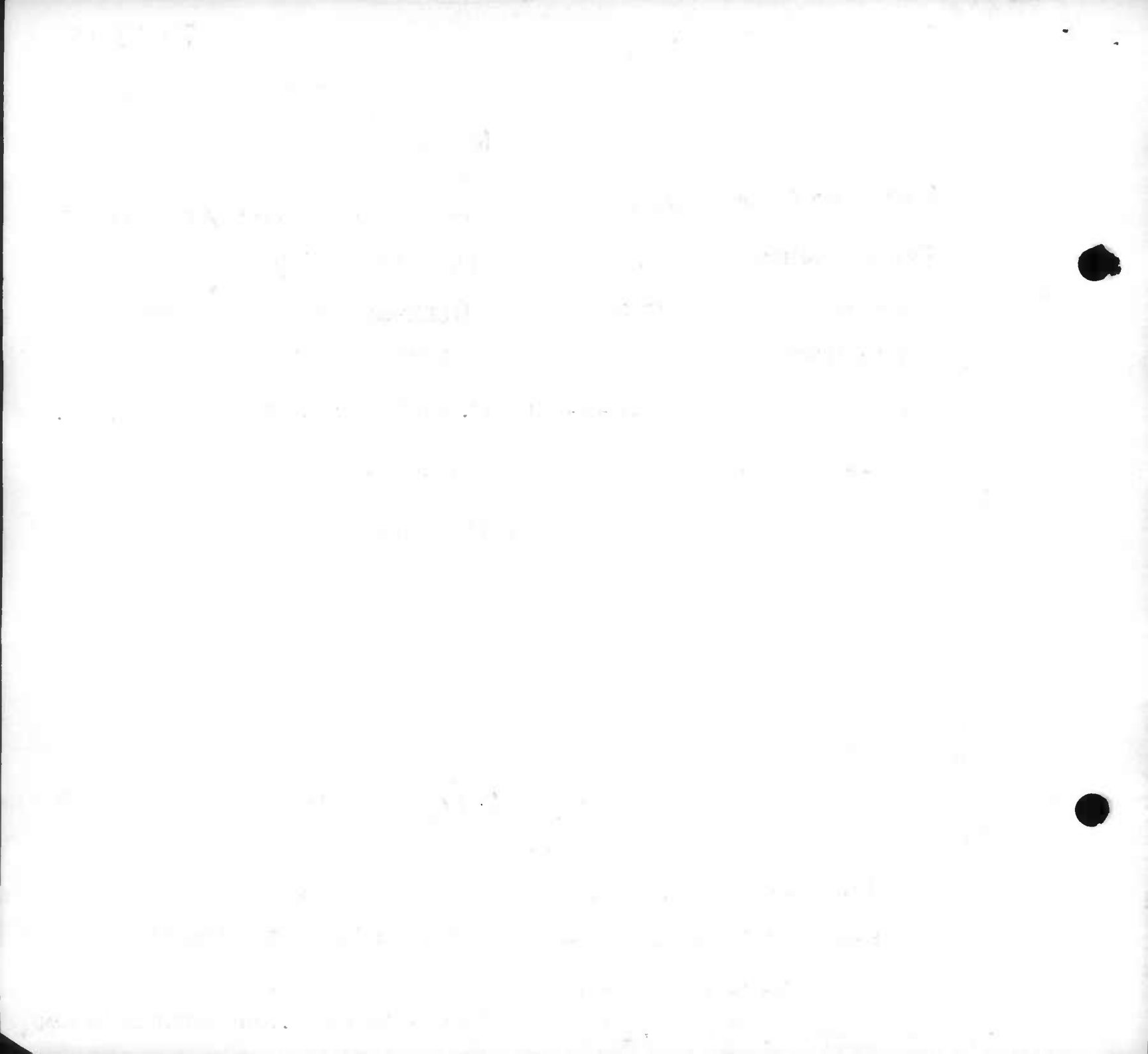
V.S. 153

1-7-71

M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12818</u>	
70 12818				CERTIFICATE OF DEATH	
BIRTH NO. <u>H-416</u>		1. NAME OF DECEASED (Type or Print) <u>DORA HELPRIN</u>		2. DATE AND HOUR OF DEATH <u>12/30/70</u> <u>8 A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSP. OF BALTO.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO.</u> C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>7006 Park Heights Ave. 27750</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/8/92</u>	9. AGE (in years last birthday) <u>78</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>ISAAC BERKOW</u>		
14. MOTHER'S MAIDEN NAME <u>ESSIE ?</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>218-32-2019A</u>			17. INFORMANT <u>MRS. NAOMI SHAPIRO, 3707 CLARKS LANE, APT. D</u>		
18. <u>410.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>MI</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Atherosclerosis</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>12/30/70</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>MI</u> 20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/30</u> 19 <u>70</u> to <u>12/30</u> 19 <u>70</u> that <u>us</u> (we) last saw the deceased alive on <u>12/30</u> 19 <u>70</u> and that <u>in</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <u>not</u> view the body after death.					
23A. SIGNATURE <u>Fortunato V. Elizaga, M.D.</u>			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>FORTUNATO V. ELIZAGA</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>12-31-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ATZ CHAIN</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1971</u>			25B. NAME OF REGISTRAR <u>Robert E. Fisher, R.D.</u>		25C. FUNERAL DIRECTOR <u>SOE LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>



70 12819 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 70 12819

1. NAME OF DECEASED (Type or Print) IRVING XX. BERMAN

2. DATE OF DEATH Known ☐ Month Day Year Hour M.  
Estimated ☐ M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  
HOSPITAL  
OR INSTITUTION  
1002 N. Calvert Street

3. DATE PRONOUNCED DEAD Month Day Year Hour M.  
December 29, 1970 8:20 P.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY

6. SEX Male 7. RACE White 8. MARRIED ☐ NEVER MARRIED ☒  
WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH DEC. 15, 1910 10. AGE (In years lost birthday) 60 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND  
12. CITIZEN OF WHAT COUNTRY? USA 13. FATHER'S NAME REUBEN BERMAN

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN 14B. KIND OF BUSINESS OR INDUSTRY RETAIL 15. MOTHER'S MAIDEN NAME SARA CAPLAN

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO 17. SOCIAL SECURITY NO. 18. INFORMANT ADDRESS  
MR. FRANK BERMAN, 4300 N. CALVERT ST., APT. 7G

19. 412.21 CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  
Hypertensive cardiovascular disease  
(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:  
(B) DUE TO, OR AS A CONSEQUENCE OF:  
(C) DUE TO, OR AS A CONSEQUENCE OF:  
II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) no

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐  
ACTUAL SIGNATURE Ronald N. Kornblum M.D. CHIEF MEDICAL EXAMINER ☐  
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED 12/30/70  
ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 12-31-70 24C. NAME OF CEMETERY or CREMATORY MIKRO KODESH 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT. JAN 5 1971 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD

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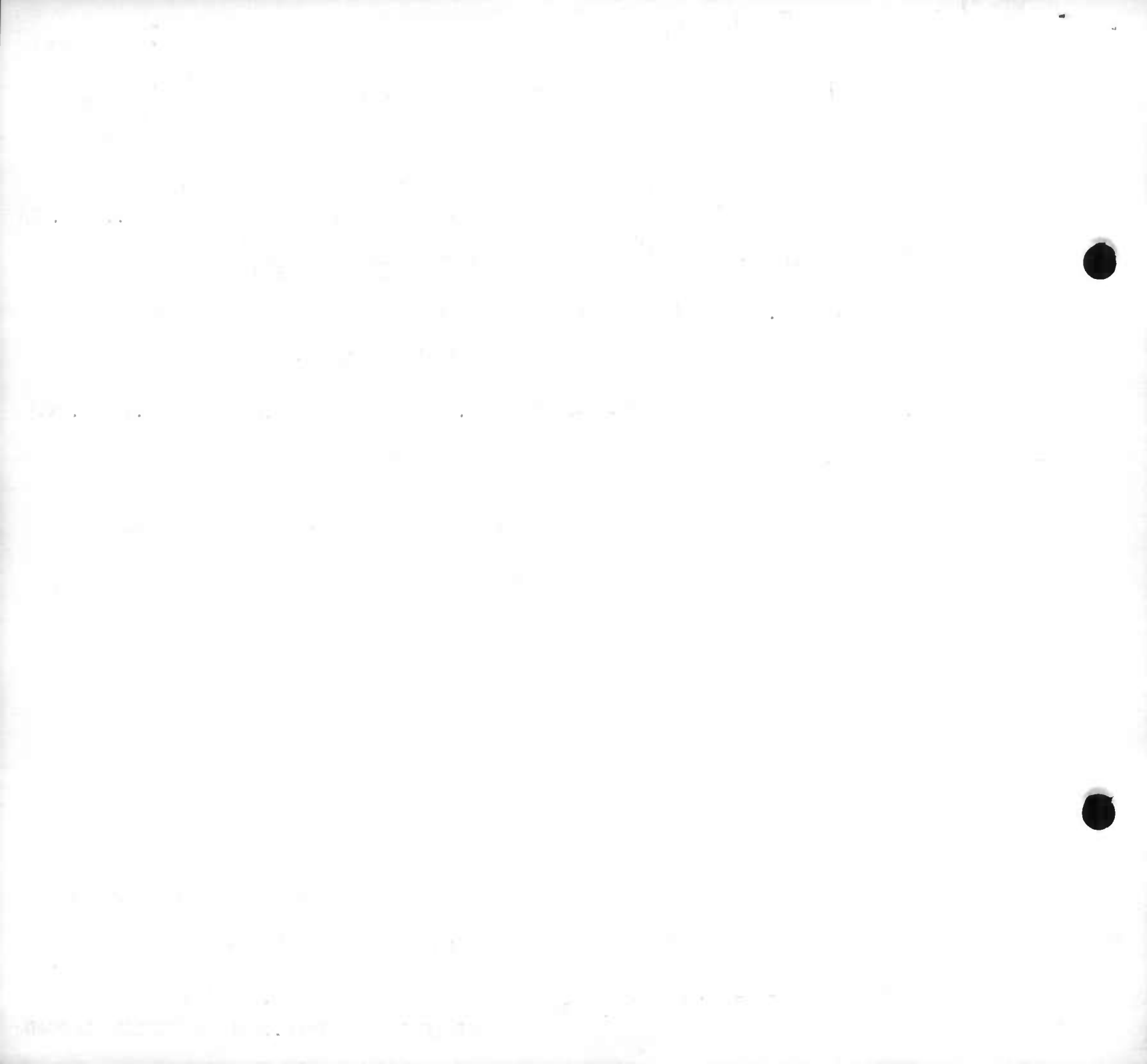
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

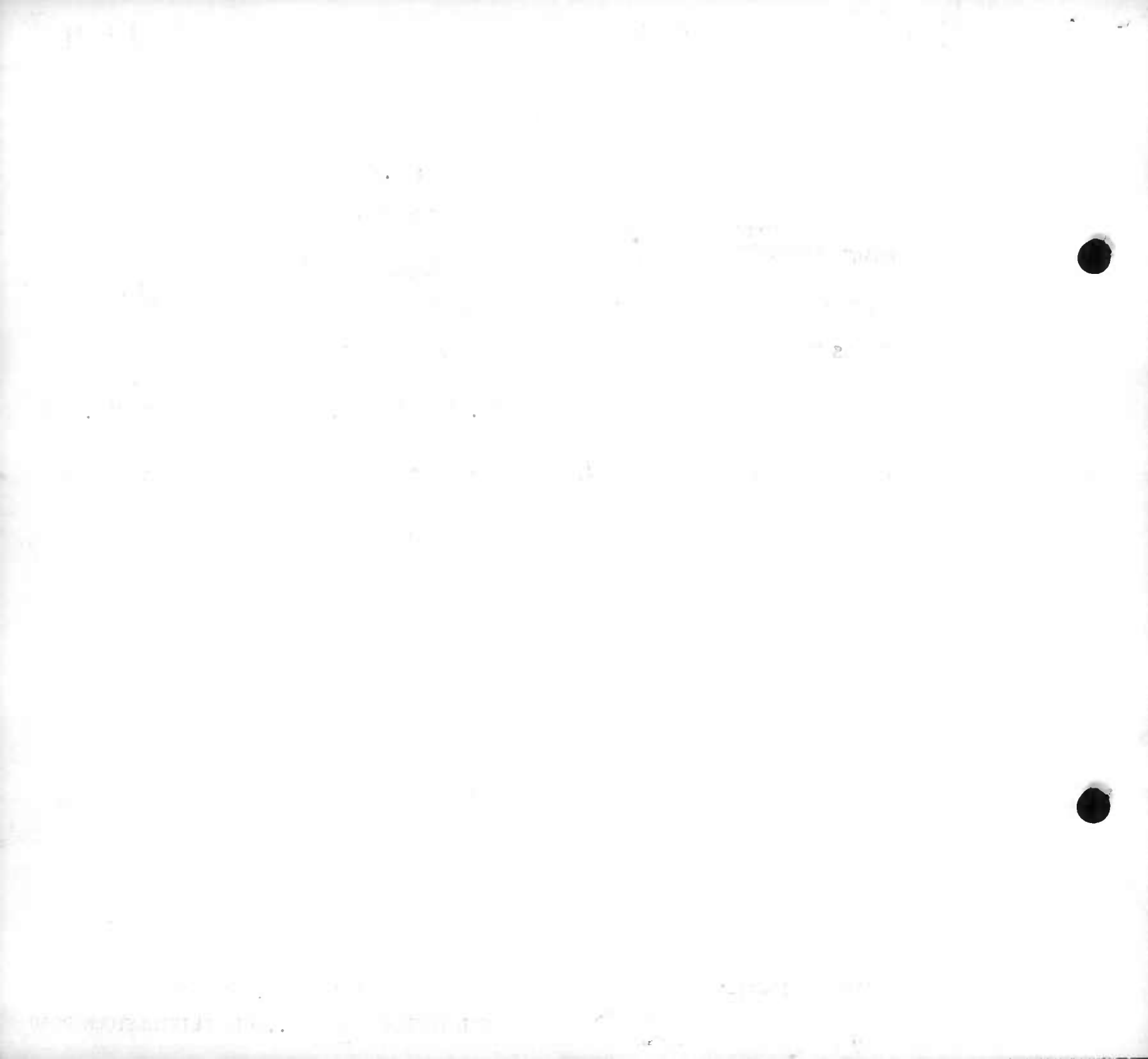
F-260 70 12820				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 12820	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				FISCHER, SOLOMON IRVING		12/29/70		8:30 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY			
42 Sineu hospital				C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER		5 AMLEHT CT., APT. 2A			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		1/29/05		65	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
CHECKER CAB CO.				SUPERINTENDENT		Russia		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
UNKNOWN				LEAH YOCHELSON					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO				214-03-0081A		MRS. BEATRICE FISCHER, 5 AMLEHT CT., APT. 2A			
18. CAUSE OF DEATH								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		MI - Pulmonary edema		Hours	
1. This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.				(B) DUE TO, OR AS A CONSEQUENCE OF:		ASCARD - CHF		Years	
ANTECEDENT CAUSES				(C) DUE TO, OR AS A CONSEQUENCE OF:		Diabetes		Years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/29/70 to 12/29 1970									
that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Hoorazar 1068. M.D.				12/29/70					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
HOORAZAR. M.D.				Sineu hospital Balto - Md. 21205					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
BURIAL		12-31-70		TIFERETH ISRAEL ANSHE SFARD		ROSEDALE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JAN 5 1971		R. E. J. M.D.		SOL LEVINSON & BROS.		6010 REISTERSTOWN ROAD			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

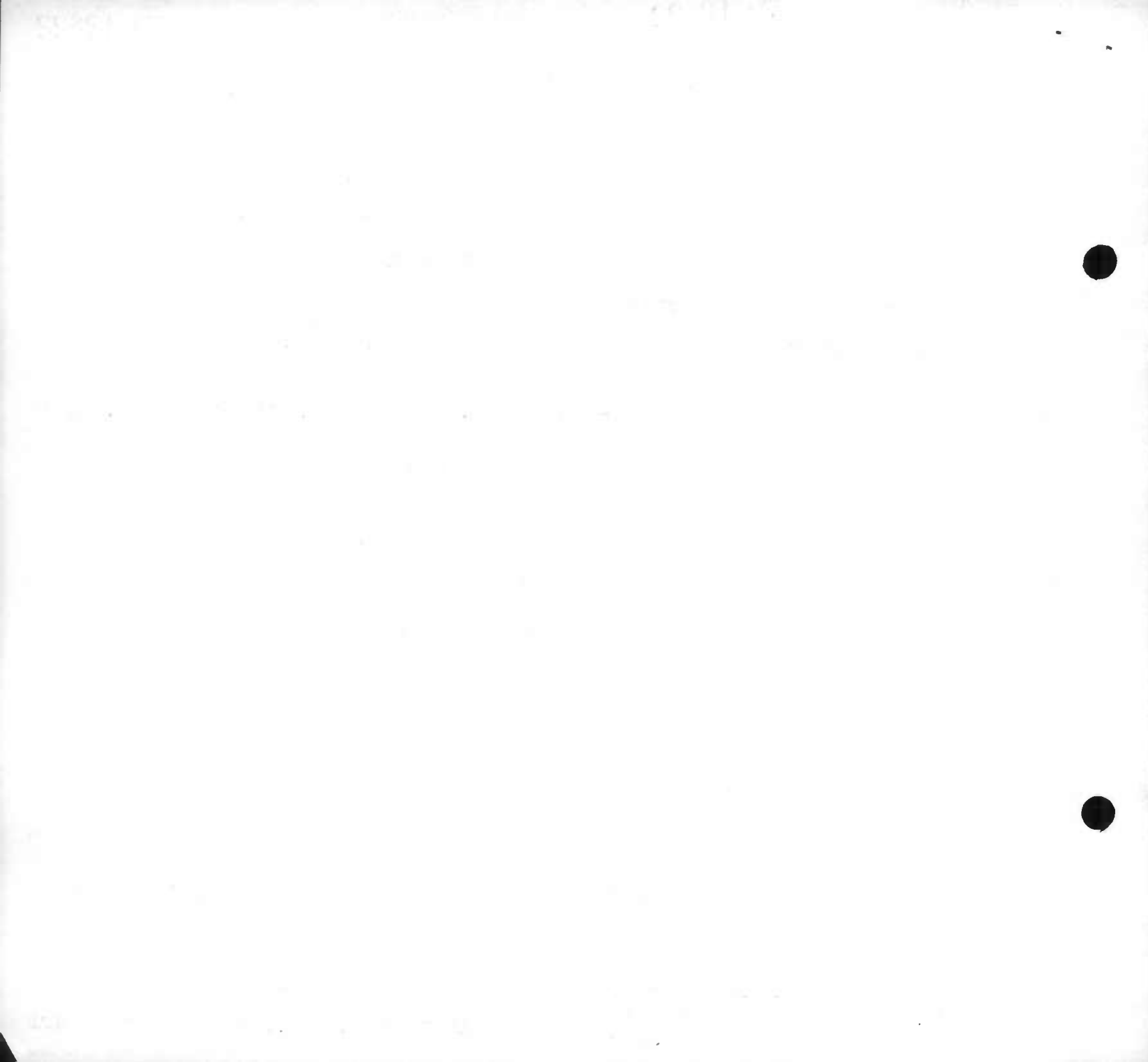
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12821</u>	
70 12821				CERTIFICATE OF DEATH	
BIRTH NO. <u>V-455</u>		1. NAME OF DECEASED (Type or Print) <u>VOLMAN, FRIEDA</u>		2. DATE AND HOUR OF DEATH <u>30<sup>th</sup> Dec 1970</u>   <u>2:45 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <u>SINAI HOSPITAL OF BALTIMORE INC.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY _____		C. CITY OR TOWN <u>BALTO, MRE</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTIMORE INC.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>6708 PARK HEIGHTS AVENUE</u>		<u>2720</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>85</u>	9. AGE (In years lost birthday) <u>85</u>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>MARCUS FEIGIN</u>		14. MOTHER'S MAIDEN NAME <u>SARAH ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>MR. ALEX VOLMAN, 6708 PARK HEIGHTS AVE. #15</u>	
18. <u>5609 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF: <u>aspiration</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 mins</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>Intestinal obstruction.</u> DUE TO, OR AS A CONSEQUENCE OF: <u>about 2 days</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>30<sup>th</sup> Dec 1970</u> to <u>30<sup>th</sup> Dec. 1970</u> that (I) (we) lost saw the deceased alive on <u>30<sup>th</sup> Dec. 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Prasad MB, BS</u>		23B. DATE SIGNED <u>30<sup>th</sup> Dec 1970</u>			
23C. PHYSICIAN'S NAME (Type) <u>P. PRASAD MB, BS</u>		23D. ADDRESS <u>Sinai Hospital of Baltimore</u> <u>Belvedere Ave., BALTIMORE, Md 21215</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-31-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>CHIZUK AMUNO</u>	
24D. LOCATION <u>BALTIMORE, MARYLAND</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 12822</span>	
CERTIFICATE OF DEATH					
BIRTH NO. <span style="font-size: 2em;">8-255</span>		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.5em;">MAX RXXXXXXX RICHMAN</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.5em;">12-30-70</span> <span style="float: right;">3:50 P. M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">91 LEVINDALE HEBREW HOME + INFIRMARY</span>			A. STATE <span style="font-size: 1.5em;">MARYLAND</span>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <span style="font-size: 1.5em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.5em;">4219 OAKFORD AVENUE</span>		
5. SEX <span style="font-size: 1.5em;">MALE</span>	6. RACE <span style="font-size: 1.5em;">WHITE</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.5em;">XXXXXX</span>	9. AGE (in years last birthday) <span style="font-size: 1.5em;">90</span>	10. Under 1 Yr. 11. Under 24 Hrs. 12. Under 1 Yr. 13. Under 24 Hrs. 14. Under 1 Yr. 15. Under 24 Hrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">MERCHANT</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.5em;">RETAIL</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.5em;">RUSSIA</span>	
13. FATHER'S NAME <span style="font-size: 1.5em;">JONAS RICHMAN</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">IDA AARONOFF</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <span style="font-size: 1.5em;">219-07-2891</span>		17. INFORMANT ADDRESS <span style="font-size: 1.5em;">MRS. ESTHER HANKIN, 4219 OAKFORD AVE. #21215</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.5em;">Pulmonary edema</span>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.5em;">1 wk.</span>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Pulmonary infarction</span>		
			(B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">ASHD</span>		
			(C) <span style="font-size: 1.5em;">Old C.V.A with urinary infection</span>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.5em;">O</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.5em;">NO</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">10-29-1968</span> to <span style="font-size: 1.5em;">12-30-1970</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">30th Dec 1970</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Kamal M. Jain</span>				23B. DATE SIGNED <span style="font-size: 1.5em;">30th Dec. 1970</span>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
DEGREE					
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.5em;">BURIAL</span>		24B. DATE <span style="font-size: 1.5em;">12-31-70</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.5em;">ANSHE NESNIA</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.5em;">ROSEDALE, MARYLAND</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">JAN 5 1971</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">R. E. F. JR.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.5em;">SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</span>			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">70 12823</span>	
BIRTH NO. <span style="float: right;">70 12823</span>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>BILLIAN, ISIDORE</b>			2. DATE AND HOUR OF DEATH <b>12/30/70 6 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42/99 SINAI HOSP. OF BALTO., INC.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2500 W. BELVEDERE AVE. 2717</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/24/91</b>	9. AGE (In years last birthday) <b>79</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>MERCHANT</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>GERSHEN BILLIAN</b>		
14. MOTHER'S MAIDEN NAME <b>CHAIKA ?</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>A</b>			17. INFORMANT ADDRESS <b>MR. STANLEY BILLIAN, 3308 LAURI RD. #21207</b>		
18. <b>4124 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ASCVD</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>CAUSE OF DEATH</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/30/1970</b> to <b>12/30/1970</b> that (I) (we) last saw the deceased alive on <b>12/30/1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Vichai Atichartakarn / Dr. M.S. Druskin M.D.</b>				23B. DATE SIGNED <b>12/30/70</b>	
23C. PHYSICIAN'S NAME (Type) <b>VICHAJ ATICHARTAKARN / Dr. M.S. DRUSKIN M.D.</b>				23D. ADDRESS <b>SINAI HOSP. OF BALTO., INC.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-31-70</b>		24C. NAME of CEMETERY or CREMATORY <b>BETH TFILOH,</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1971</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			

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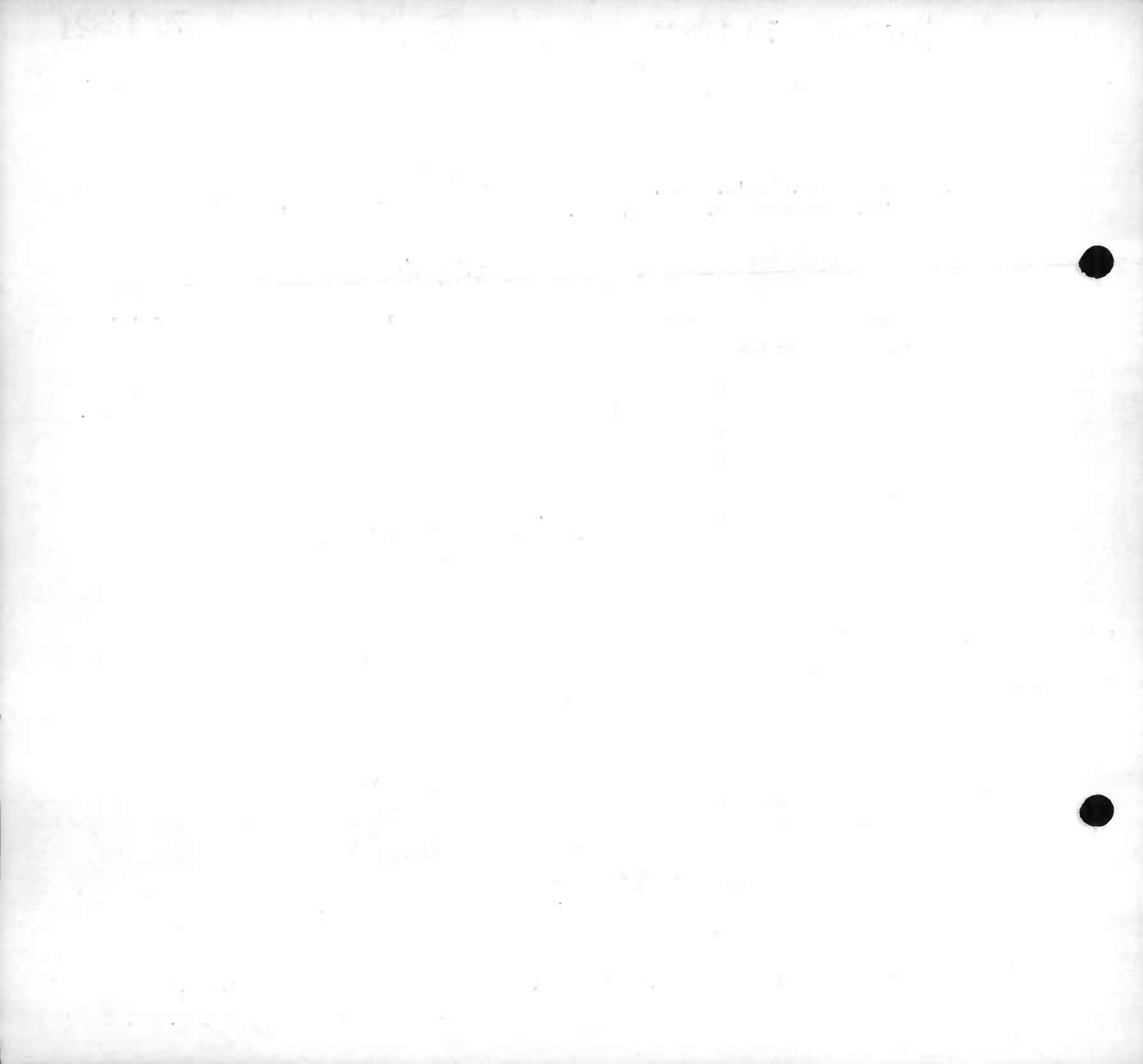
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

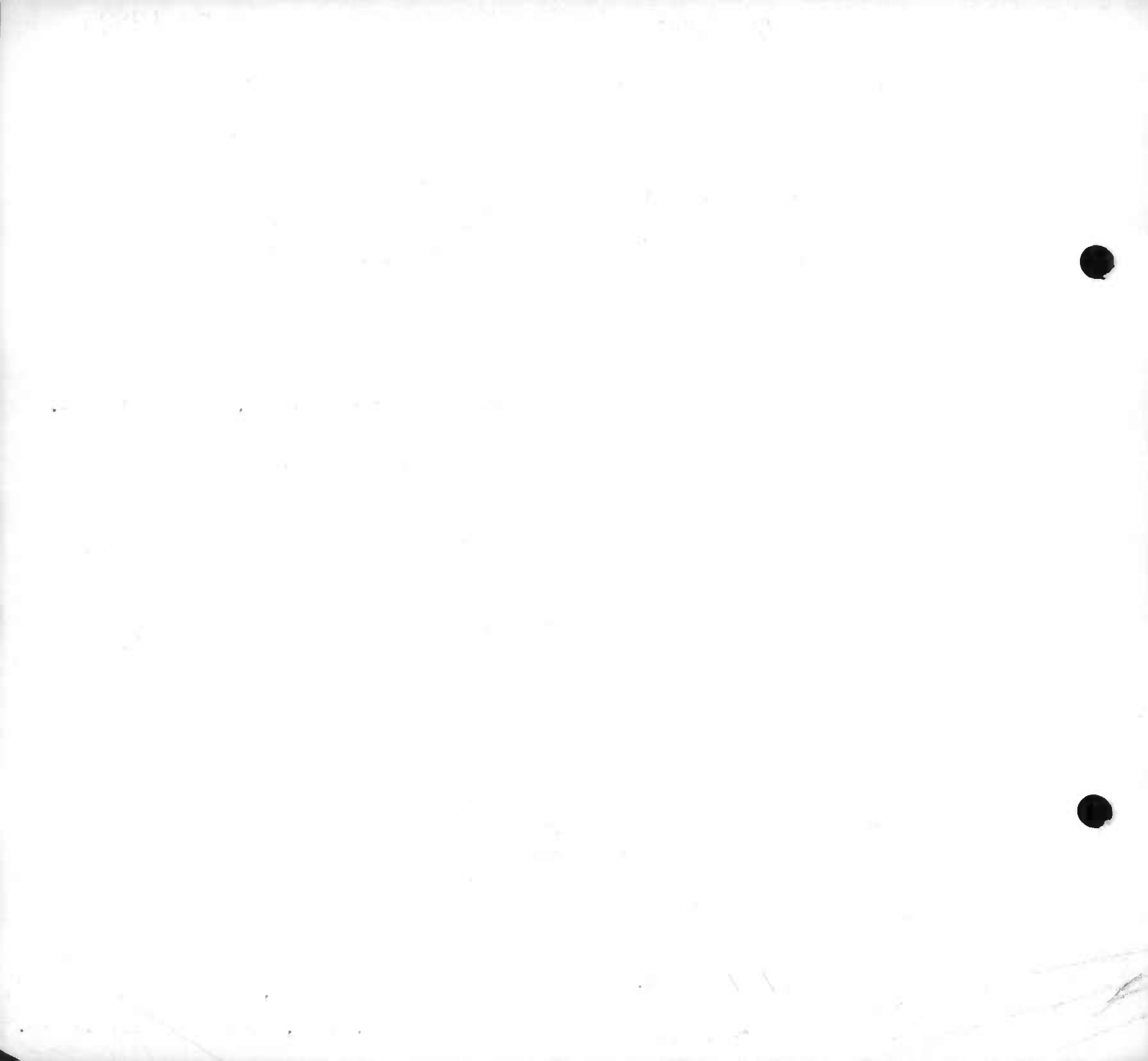
BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 70 12824	
<div style="display: flex; justify-content: space-between;"> <span>1-532</span> <span>70 12824</span> </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>Mechtilde Jentzsch</b>			2. DATE AND HOUR OF DEATH <b>12/29/70 4:50 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>AA</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>South Balto. Gen'l. Hosp. 3000 S. Hanover St. Balto. Md.</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>409 Cresswell Rd. 21225</b>		
5. SEX <b>F</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8 / 15 / 1888</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Munich, Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Unknown Schmitt</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215 24 5004</b>	17. INFORMANT <b>Martha Ann Schmidt 409 Cresswell Rd. 21225</b>		
18. <b>410.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary occlusion</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Sept 17 1967</b> to <b>Dec 29 1970</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Dec 15 1970</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <b>Philip W. Keister M.D.</b>			23B. DATE SIGNED <b>12/31/70</b>		
23C. PHYSICIAN'S NAME (Type) <b>KEISTER</b>			23D. ADDRESS <b>302 Patapsco Ave Balto 25</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/2/71</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Olive Cem.</b>	
				24D. LOCATION (City, town, or county) <b>Randallstown, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1971</b>		25B. NAME OF REGISTRAR <b>Robert C. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>McCully Funeral Home Balto. Md. 21225</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

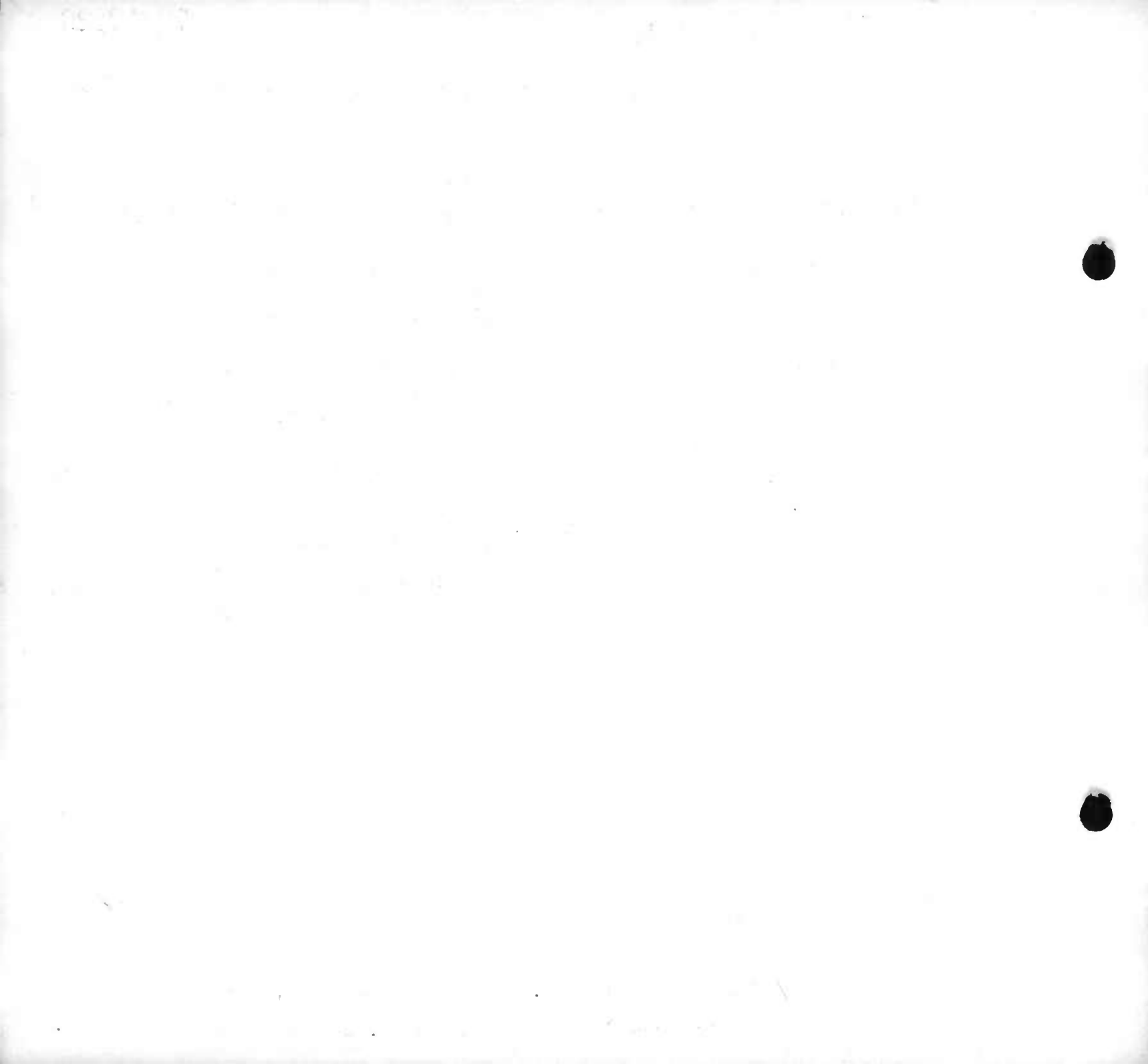
BALTIMORE CITY HEALTH DEPARTMENT				70 12825	
BIRTH NO.				70 12825	
1. NAME OF DECEASED (Type or Print) <u>Joseph Jackson</u>			2. DATE AND HOUR OF DEATH <u>12-27-70</u> <u>146p.m.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hospital</u>			A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		
			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <u>3311 Edmondson Ave 2037</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-97</u>	9. AGE (In years lost birthday) <u>72</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <u>Africa</u>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <u>Britannia</u>		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>—</u>		
			17. INFORMANT <u>Bishop Monroe Saunders, 3400 Copley Rd.</u>		
18. <u>410,914-250,9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>HAS CVD</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Diabetes Mellitus</u>		
			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>years</u> <u>years</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>12-23-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>human retention</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NA</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>NA</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>Dec 19</u> 19 <u>70</u> to <u>Dec 27</u> 19 <u>70</u> and that (I) (we) last saw the deceased alive on <u>Dec 27</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Joseph E. Taylor</u>				23B. DATE SIGNED <u>12-27-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Joseph E. Taylor</u>				23D. ADDRESS <u>Kenneth H. Law, 4609 Park Heights Ave.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/30/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. DATE RECEIVED BY HEALTH DEPT. <u>JAN 5 1971</u>			
25A. NAME OF REGISTRAR <u>John E. Taylor</u>		25B. FUNERAL DIRECTOR <u>Kenneth H. Law</u>			
25C. ADDRESS <u>4609 Park Heights Ave.</u>					



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

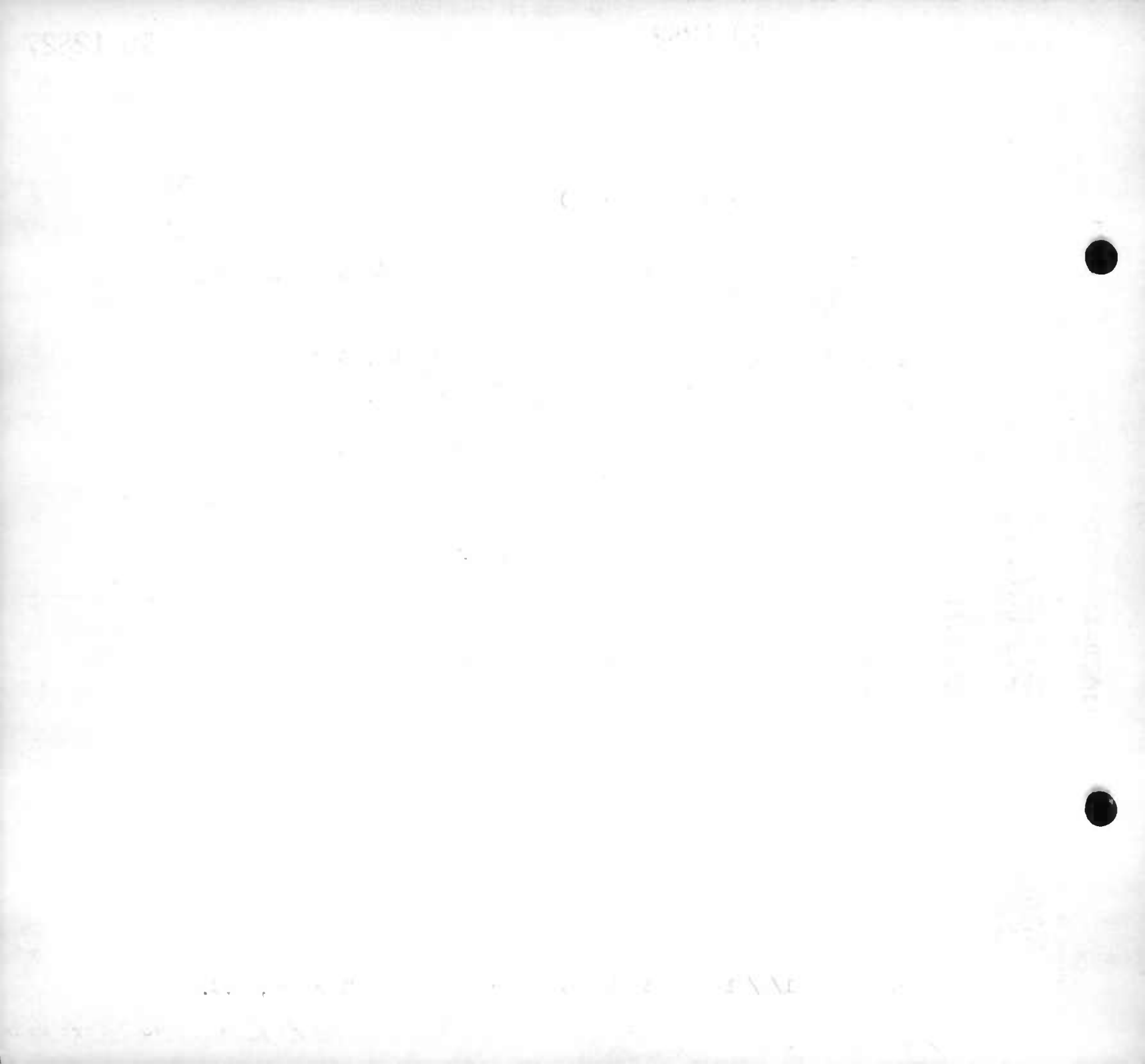
<b>70 12826</b> REG. NO.		<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		<b>70 12826</b>	
BIRTH NO. <b>G-352</b>		1. NAME OF DECEASED (Type or Print) <b>Clarence &amp; James Gittings, Sr.</b>		2. DATE AND HOUR OF DEATH <b>12/31/70 3:58 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>3408 Rosedale Road.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Same</b> B. COUNTY		5. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>3408 Rosedale Road.</b>		E. STREET AND NUMBER <b>3408 Rosedale Road 1511</b>		6. SEX <b>M</b> 7. RACE <b>Neuro</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday) <b>84</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Postal Carrier Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Talbot</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>220-44-7582-T</b>		17. INFORMANT <b>Clarence J. Gittings Jr.</b>		ADDRESS	
18. CAUSE OF DEATH <b>412.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Uremia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arterio-sclerotic</b> <b>Hypertensive Cardio-Vascular Disease 19 yrs.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 da.</b>		19. DATE OF OPERATION <b>0</b>	
20. AUTOPSY? (Yes or No) <b>No</b>		21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>Aug 1951</b> to <b>Dec 31st 1970</b> that (I) <del>(we)</del> last saw the deceased alive on <b>Dec 30th 1970</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> <del>(did)</del> view the body after death.	
23A. SIGNATURE <b>R. Browne</b>		23B. DATE SIGNED <b>1/1/71</b>		23C. PHYSICIAN'S NAME (Type) <b>RAYNER BROWNE, M.D.</b> <b>1500 EAST MADISON ST.</b> <b>BALTIMORE, MD. 21205</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/4/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1971</b>		25B. NAME OF REGISTRAR <b>Kenneth H. Law</b>	
25C. FUNERAL DIRECTOR <b>Kenneth H. Law</b>		ADDRESS <b>4609 Park Heights Ave.</b>		VS 150-REV. 1/1/68	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

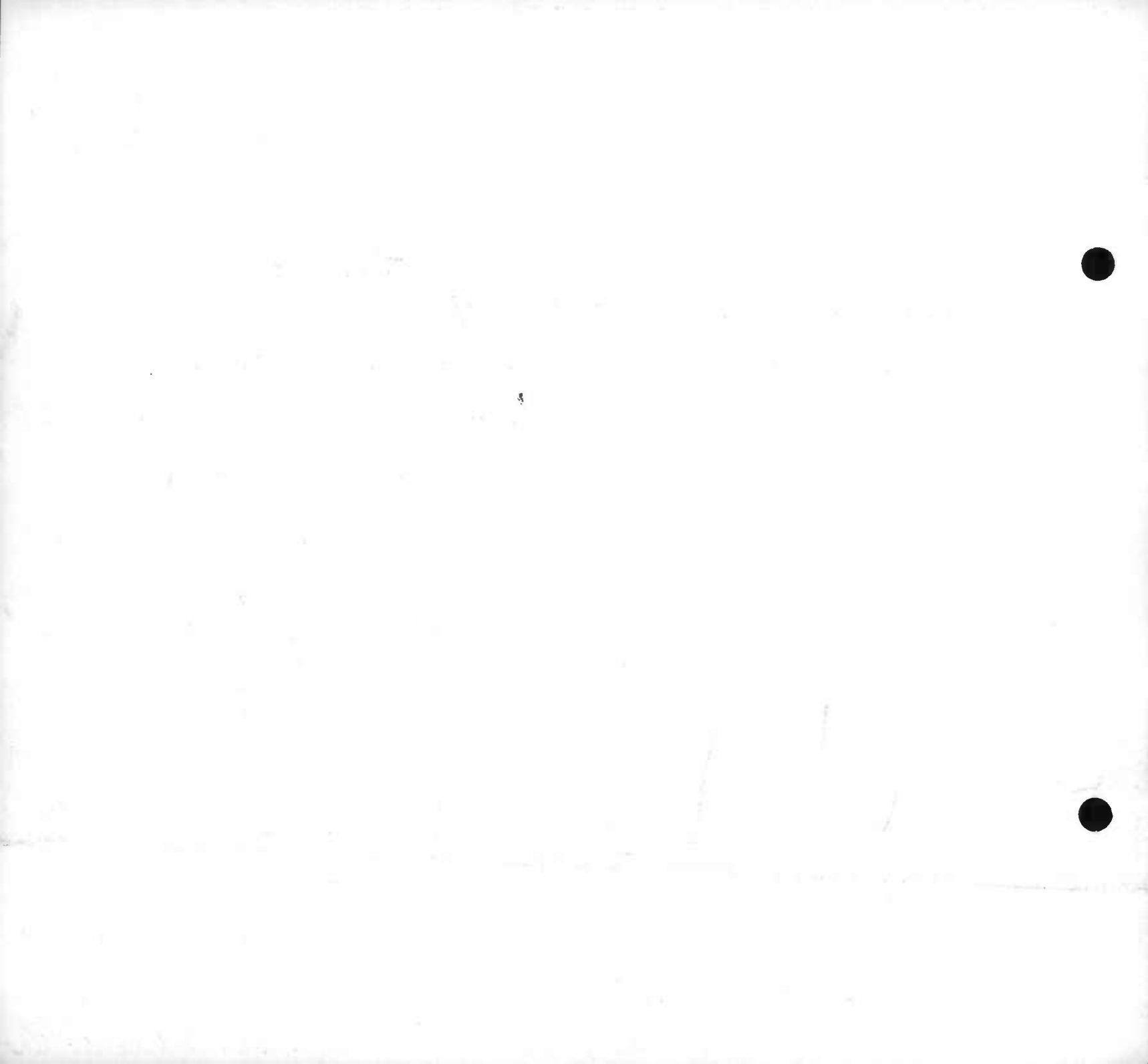
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>342157</u>	
BIRTH NO. <u>S-536</u>		70 12827		70 12827	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>SAUNDERS Mr. LAWRENCE.</u>				2. DATE AND HOUR OF DEATH <u>12/30/70</u> <u>8:50</u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 MGH (Maryland General)</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>S.C.</u> B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Florence</u>	
				D. STREET ADDRESS (If rural, give location) <u>3002 Hilton Street 1007 Parkway</u>	
5. SEX <u>M</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>	8. DATE OF BIRTH <u>2-15-83</u>	9. AGE (In years last birthday) <u>87</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>S.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Richard Saunders</u>		
14. MOTHER'S MAIDEN NAME <u>Millie Hunter</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>250-74-5214</u>			17. INFORMANT <u>face-sheet</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>BRONCHOPNEUMONIA</u>			INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO <u>HEPATIC INFARCT, LARGE</u>		
			(B) DUE TO <u>ATHEROSCLEROSIS</u>		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-11-70</u> to <u>12-30-70</u> and that (I) (we) last saw the deceased alive on <u>12/30</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Manejul</u>				23B. DATE SIGNED <u>12/30/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>MANEJUL</u>				23D. ADDRESS <u>MOBY</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/4/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Zion Cemetery</u>	
24D. LOCATION <u>Florence, S.C.</u>		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Kenneth Law</u>	
ADDRESS <u>4609 Park Hgts</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
70 12828					REG. NO. 70 12828				
BIRTH NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <u>Elijah Walker</u>					December 30, 1970 11:40 <sup>EST</sup> AM				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Mt. Sinai Nursing Home</u> <u>90</u>					A. STATE <u>Maryland</u>		B. COUNTY <u>Baltimore</u>		
					C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER <u>1805 Rutland Ave.</u> <u>806</u>				
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-1887</u>	9. AGE (in years last birthday) <u>83</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Laborer - Eastern Steelworks</u>	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME <u>Cephaw Walker</u>					14. MOTHER'S MAIDEN NAME <u>Bella Morris</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO.		17. INFORMANT <u>Wilbert Walker</u>		
18. <u>436,917-093,9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE <u>Recurrent Pulmonary Emboli</u> 9 days				
					(B) <u>Cerebrovascular Accident (right)</u> 6 wks				
					(C) <u>Embolism from heart vs arteriosclerotic cerebrovascular</u>				
ANTECEDENT CAUSES									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					1) <u>Arteriosclerotic heart disease</u> 2) <u>old Myocardial infarction</u> 3) <u>Arteric stenosis + insufficiency</u> 4) <u>probable 2° Aortic aortitis</u> 5) <u>Renal insufficiency</u> 6) <u>2° Anemia</u> 7) <u>Recurrent urinary tract infection</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>Dec 14</u> 19 <u>70</u> to <u>Dec 30</u> 19 <u>70</u> that (I) ( <u>we</u> ) last saw the deceased alive on <u>Dec 28</u> 19 <u>70</u> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>we</u> ) (did) ( <u>did not</u> ) view the body after death.									
23A. SIGNATURE <u>Henry J. Babitt, MD</u>					23B. DATE SIGNED <u>Dec 30, 1970</u>			23C. PHYSICIAN'S NAME (Type) <u>Henry J. Babitt, MD</u>	
23D. ADDRESS <u>4623 Hawksbury Rd Balt, Md</u>					24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				
24B. DATE <u>1-4-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MT. CALVARY CEM.</u>		24D. LOCATION (City, town, or county) (State) <u>999. County, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Babitt, MD</u>		25C. FUNERAL DIRECTOR <u>Ellen's Funeral Home</u>					



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>MOSES ALLEN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 919 N. Chapel Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>December 29, 1970</b> Hour <b>9:50 P.</b> M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
9. DATE OF BIRTH <b>7-02-05</b>		10. AGE (In years last birthday) <b>65</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Allen</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
15. MOTHER'S MAIDEN NAME <b>Bessie ?</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Elizabeth Ward-1113 N. Bond St</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>E9161X</b> <b>Pulmonary Embolism</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>(b) Phlebothrombosis right leg</b> <b>(c) Fracture right tibia and fibula (Healed)</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b> <b>Fatty metamorphosis of Liver</b>			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Work</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>4-30-69 ? m.</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Unk.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Timber fell on right leg</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>[Signature]</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-5-71</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Westport, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Ed. Att. Funeral Home</b>		ADDRESS <b>1129 N. Caroline</b>	

POST OFFICE

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L000		70 12830		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12830	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>ALEXANDER LEE</u>				2. DATE AND HOUR OF DEATH <u>12/27/70</u> <u>12</u> <u>P</u> <u>M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MARYLAND</u>		B. COUNTY	
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1748 CARSWELL ST</u>		<u>907</u>	
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/1/92</u>	9. AGE (In years last birthday) <u>78</u>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Z</u>				14. MOTHER'S MAIDEN NAME <u>Z</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Myrtle Lee, 1748 Carswell St. Balto. 18</u>	
18. <u>41-41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Septicemia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pneumonia</u> <u>History of stroke ASCVD</u> <u>UTI, prostate hypertrophy</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>12/27/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Not for medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>December 20</u> 19 <u>70</u> to <u>December 27</u> 19 <u>70</u> that (1) (we) last saw the deceased alive on <u>December 27</u> 19 <u>70</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Karl C. Fazeekas MD</u>				23B. DATE SIGNED <u>12/27</u>		23C. PHYSICIAN'S NAME (Type) <u>Karl C. FAZEKAS MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-31-70</u>		<u>Arbutus Memorial Park</u>		<u>Arbutus, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
<u>JAN 5 1971</u>		<u>Robert E. Taylor, M.D.</u>		<u>Robert E. Taylor</u>		<u>11297 Carlinville</u>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12831	
<div style="display: flex; justify-content: space-between;"> <div> <p>26 30 84 WILLIS ARTHUR 10 30 32</p> <p>70 12831</p> </div> <div> <p style="font-size: 24pt; font-weight: bold;">CERTIFICATE OF DEATH</p> </div> </div>					
1. NAME OF DECEASED (Type or Print) <i>Arthur Willis</i>		2. DATE AND HOUR OF DEATH 12/27/70 10:30 p. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>The Johns Hopkins Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
33		E. STREET AND NUMBER <i>1114 Central Avenue</i>		1001	
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/30/22</i>	9. AGE (In years last birthday) <i>48</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>City</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John ?</i>		14. MOTHER'S MAIDEN NAME <i>Bessie Harris</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Bessie Harrison</i>	
18. ADDRESS <i>1114 Central Ave</i>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral + Cerebellar infarction - 36 hrs</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Unknown</i> DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/26</i> 19 <i>70</i> to <i>12/27</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>12/27</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John M. Amatruda MD</i>				23B. DATE SIGNED <i>12/27/70</i>	
23C. PHYSICIAN'S NAME (Type) <i>John M. Amatruda MD</i>				23D. ADDRESS <i>601 N. Broadway</i>	
24A. BURIAL REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-4-70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn Cem</i>	
24D. LOCATION <i>Streetport, Md.</i>		24E. (State)		24F. (City, town, or county)	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 5 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber, M.D.</i>		25C. FUNERAL DIRECTOR <i>Elliot Funeral Home 1129 N. Caroline St.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12832	
BIRTH NO. 70 12832		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Alma Schofield</u>			2. DATE AND HOUR OF DEATH <u>12/31/70</u> <u>4:26</u> AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>JOHNS HOPKINS HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2118 N. WOLFE ST.</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/9/92</u>	9. AGE (In years last birthday) <u>78</u>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>JOHN BROOKS</u>			14. MOTHER'S MAIDEN NAME <u>MARY E. DEMIONS</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no (unknown)) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Bertha Sledge-2118 N. Wolfe St.</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Heart attack at hospital</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic Brain Sx.</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiac Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Terminal</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>terminal of tetanus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>&gt; 1 year</u>
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Chronic Brain Sx.</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>1968</u> to <u>Oct</u> 19 <u>70</u> that (I) <u>we</u> last saw the deceased alive on <u>Oct</u> 19 <u>70</u> and that (n) <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) (did not) <u>view the body after death.</u>					
23A. SIGNATURE <u>Bernadine H. Bulkley</u>			23B. DATE SIGNED <u>1/3/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Bernadine H. Bulkley</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>1-6-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Sabary Cerm.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1971</u>			25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>ELLIOTT Funeral Home-1129 Maryland</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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LYNCH, FLORA C.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12833	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <b>FLORA LYNCH</b>			2. DATE AND HOUR OF DEATH <b>Dec. 26 10:12 PM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>531 N. PATTERSON PARK AVE. 703</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-16-21</b>	9. AGE (In years last birthday) <b>49</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N. Carolina</b>	
13. FATHER'S NAME <b>JERRY RICHARDSON</b>		14. MOTHER'S MAIDEN NAME <b>RUTH Rudell</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Early Lynch</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary edema</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days +</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Chronic renal disease &amp; anemia</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertensive cardiovascular disease</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b>		19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 years</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <b>Dec 19 19 70</b> to <b>Dec 26 19 70</b> , that (I) ( <u>we</u> ) last saw the deceased alive on <b>Dec 26 19 70</b> and that in ( <u>my</u> ) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ( <u>did</u> ) (did not) view the body after death.					
23A. SIGNATURE <b>R. Shore</b>			23B. DATE SIGNED <b>Dec 26, 1970</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>R. SHORE</b>			23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>12-31-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Nashville, N. Carolina</b>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>ELL:ott Funeral Home</b>		25D. ADDRESS <b>129 N. Broadway</b>			



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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 12834

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Pauline Sparts (Sparks)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 28 Year 70 Hour 11:55 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION PROVIDENT HOSPITAL ADDRESS OR LOCATION 1-7-71		3. DATE PRONOUNCED DEAD Month 12 Day 28 Year 70 Hour 11:55 a.m.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY			
6. SEX female	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto.
9. DATE OF BIRTH Oct. 31, 1929 43		E. STREET AND NUMBER 3506 Fairview Avenue 1538	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Pauline Figgins	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Armos Sue Sparks		ADDRESS	
19. 441.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease with cardiac tamponade		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Dissecting hemorrhage of Aorta with Cardiac Tamponade (B) _____ DUE TO, OR AS A CONSEQUENCE OF: _____ (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. EXAMINER'S NAME (Type) DATE SIGNED: 12/28/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-31-70	
24C. NAME OF CEMETERY or CREMATORY Arbutus		24D. LOCATION (City, town, or county) (State) Arbutus, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1971		25B. NAME OF REGISTRAR Robert E. J. [unclear]	
25C. FUNERAL DIRECTOR Elbert [unclear]		ADDRESS 11297 [unclear]	

Letter from M.E.'s office

1-7-71

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 12835	
70 12835 CERTIFICATE OF DEATH				REG. NO. _____	
BIRTH NO. <span style="font-size: 1.5em;">M-460</span>					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Miller, James</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">12/30/70</span> <span style="font-size: 1.2em;">3:10</span> a. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY _____			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">39</span> <span style="font-size: 1.2em;">Provident Hospital Complex 2600 Liberty Heights Ave. Baltimore, Maryland 21215</span>		C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <span style="font-size: 1.2em;">4040 Haywood Ave.</span>		<span style="font-size: 1.5em;">2788</span>	
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">N</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">12-25-1900</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">70</span>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Unemployed</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">unknown</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Mary Green</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U. S. A.</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">218-01-2689A</span>		17. INFORMANT <span style="font-size: 1.2em;">Mrs. Dorothy Smith-Daughter</span>	
		ADDRESS <span style="font-size: 1.2em;">Same</span>			
18. <span style="font-size: 1.5em;">185X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Septisemia</span>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Urinary Tract Infection</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">2-3 days</span> <span style="font-size: 1.2em;">10 days</span>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">Carcinoma of the Prostate</span>		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">O</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <span style="font-size: 1.2em;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">12/23/70</span> 19____ to <span style="font-size: 1.2em;">12/30/70</span> 19____ that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">12/30/70</span> 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">J. K. Smith, M.D.</span>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">Dec. 30, 1970</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">VENIEDO ACIDIO MD</span>		23D. ADDRESS <span style="font-size: 1.2em;">2600 Liberty Heights Ave. Baltimore, Md.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">1-4-71</span>	24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Mt. Auburn Cmt.</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore Md</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 5 1971</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor, Jr.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Cordellson 1000 Brantly Rd</span>	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-520 70 12836		BALTIMORE CITY HEALTH DEPARTMENT		70 12836	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		James W. Haines		12-29-70 7:15 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL		Maryland Baltimore			
C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER		911 E. Fayette St. 302			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
M	N		5-2-19	51	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Ice plant worker		Comm. Ice			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
Walter Haines		Mam mie Jackson		YES	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
218-03-0070		self			
18. 239.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Massive hemorrhage possibly $\odot$ carotid artery			
		(B) Tumor $\odot$ oro-pharynx DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
12-29-70		Difficult breathing		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO		NA		-	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
-		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		-	
22. I certify that (I) (this hospital) attended the deceased from 28 Dec 1970 to 29 Dec 1970, that (I) (we) last saw the deceased alive on 29 Dec 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Ronald E. Tinsley (M.D.)				12-29-70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
RONALD E. TINSLEY		THE JOHNS HOPKINS HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1-5-71		Mt Calvary C.	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR			
Ad County - Md		Ed Wilson 1000 Brantley Ave			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. ADDRESS	
JAN 5 1971		John E. Jones			



VS 151-REV. 7/1/68

50-15-23

NO 1524

THE  
OFFICE OF THE  
SHERIFF  
COUNTY OF  
SHERMAN  
STATE OF  
MISSISSIPPI

IN RE  
THE ESTATE OF  
JAMES H. HARRIS  
DECEASED

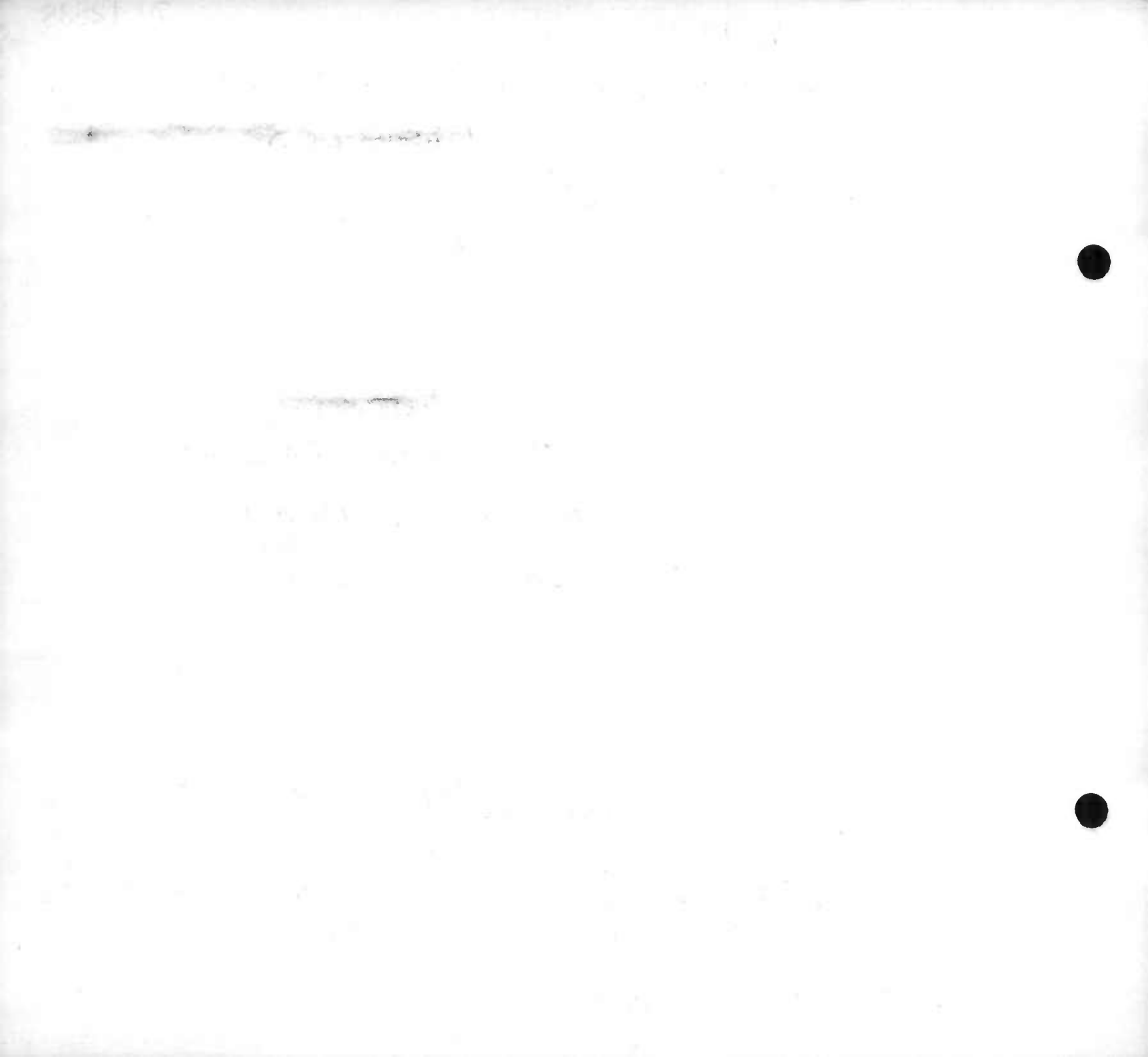
VS  
JAMES H. HARRIS  
ADMINISTRATOR

VS  
JAMES H. HARRIS  
ADMINISTRATOR

VS  
JAMES H. HARRIS  
ADMINISTRATOR

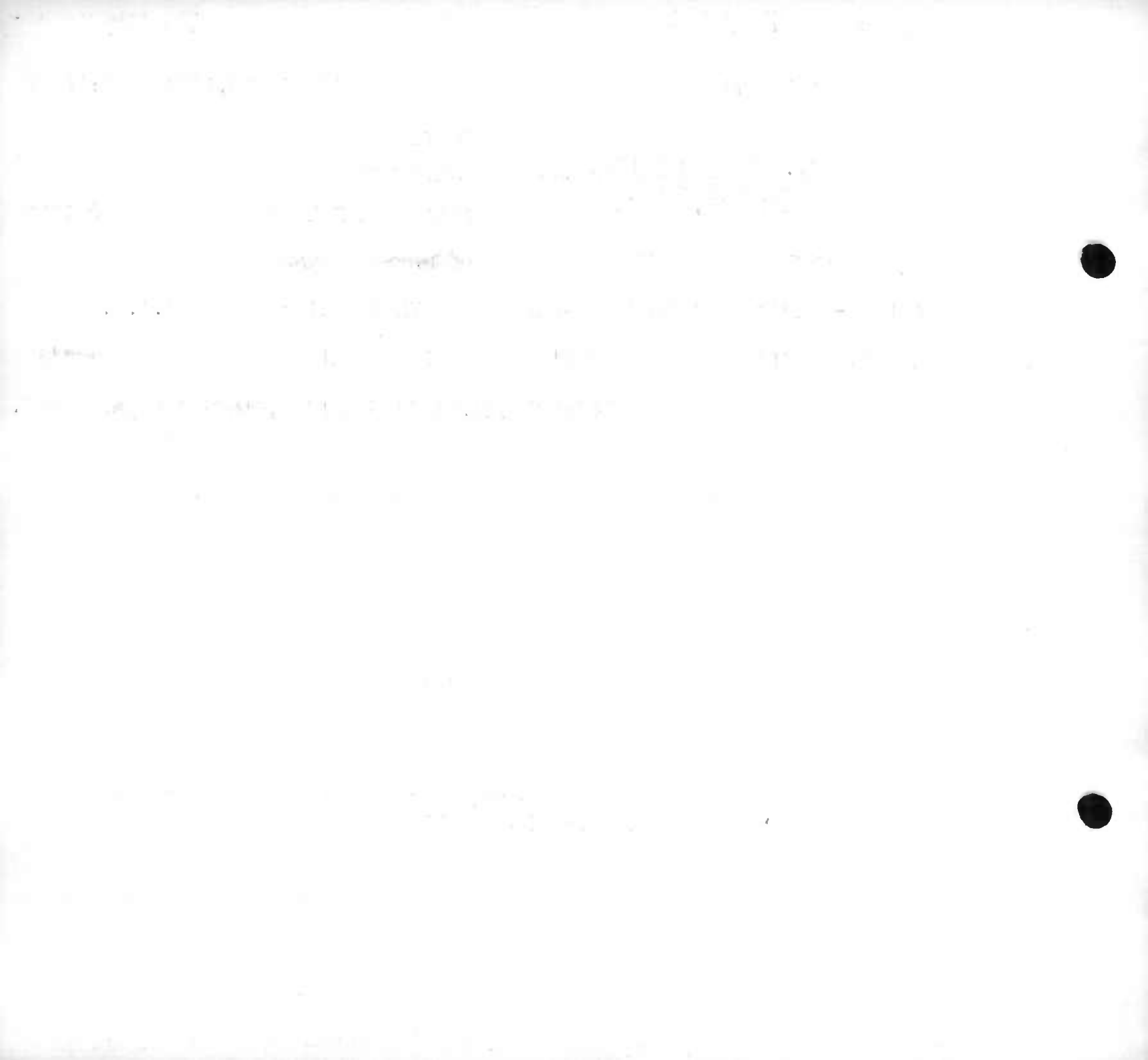
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 12838		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 12838	
BIRTH NO. 7-425		1. NAME OF DECEASED (Type or Print) <b>FAULKNER, BESSIE</b>		2. DATE AND HOUR OF DEATH <b>12/30/70 2:30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 SINAI HOSP. BALT.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3514 Oakmont Avenue</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/13/30</b>	9. AGE (In years last birthday) <b>40</b>	10. Under 1 Yr. Months: Days: (If Under 24 Hrs. Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Wards Baking Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Walter Spencer</b>		14. MOTHER'S MAIDEN NAME <b>Bessie ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>320-20-3262</b>		17. INFORMANT ADDRESS <b>Mr. Otis Faulkner 3514 Oakmont Avenue</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>RESPIRATORY FAILURE</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>METASTATIC BRAIN TUMOR</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CA OF THE LUNG</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>12/1/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/1/70</b> to <b>12/30/70</b> and that (I) (we) last saw the deceased alive on <b>12/30/70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Joseph Soliman M.D.</b>		23B. DATE SIGNED <b>12/30/70</b>		23C. PHYSICIAN'S NAME (Type) <b>JOSEPH SOLIMAN</b>	
23D. ADDRESS <b>SINAI HOSP.</b>		23E. MED. DIRECTOR <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23F. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-4-1971</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION <b>Baltimore Co. Maryland</b>		24E. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1971</b>		24F. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
24G. NUTTER FUNERAL HOME 3035 W. NORTH AVE.		24H. ADDRESS		24I. NUTTER FUNERAL HOME 3035 W. NORTH AVE.	



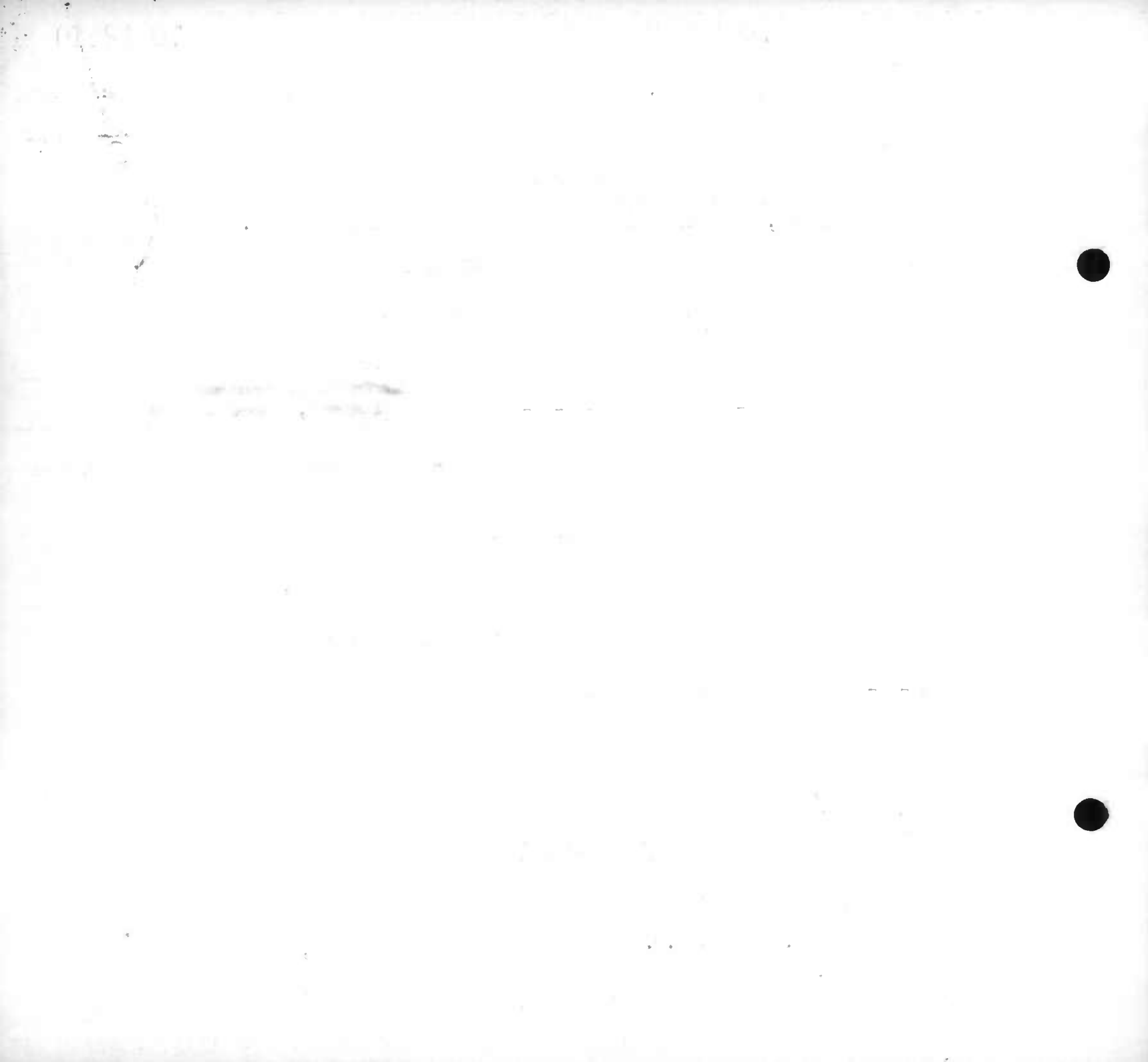
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

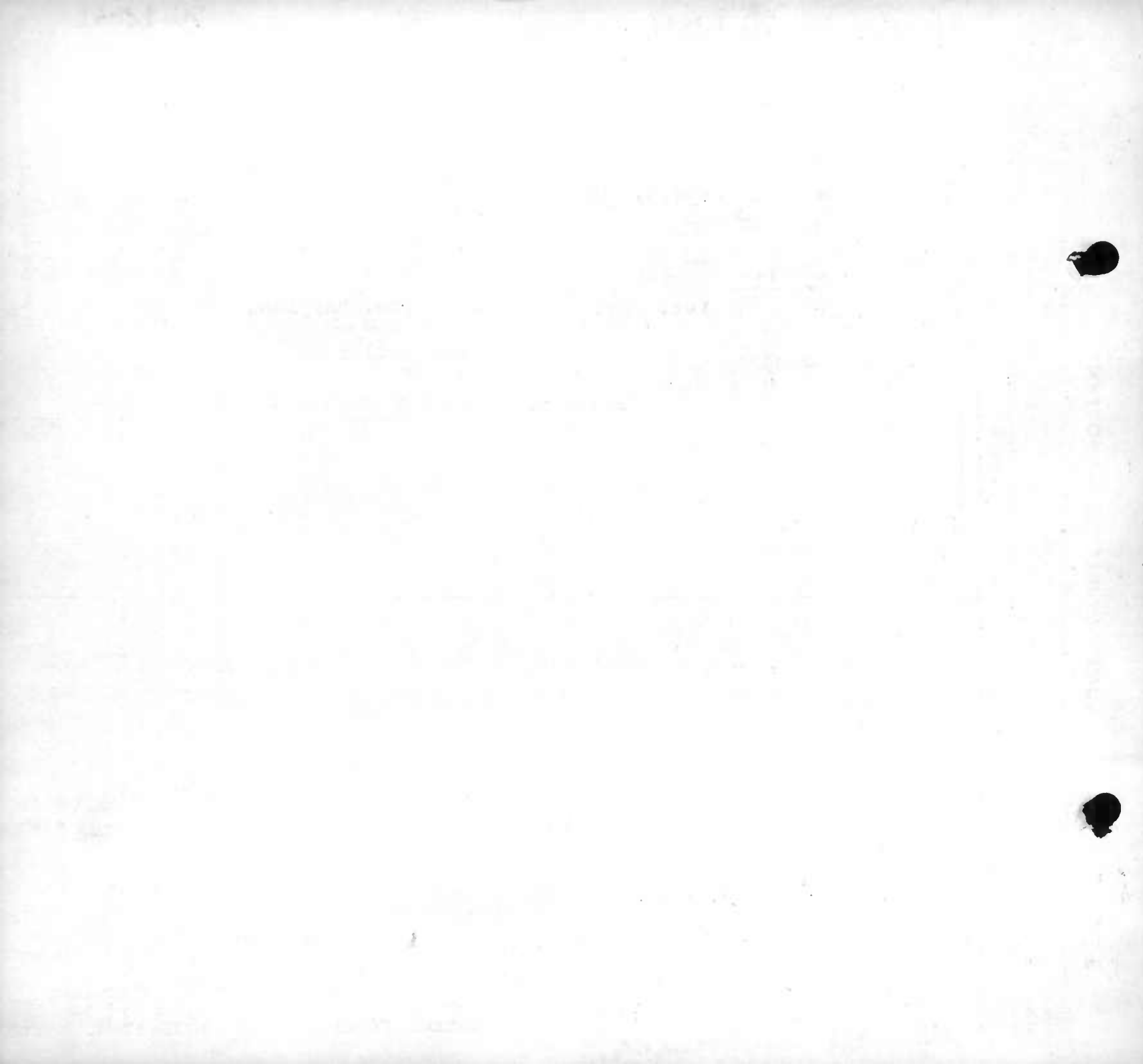
BIRTH NO. <b>B-326</b>		70 12840		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>70 12840</b>	
1. NAME OF DECEASED (Type or Print) <b>RODGERS, Norton H.</b>				2. DATE AND HOUR OF DEATH <b>December 29 1970 9:47 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b> 6. RACE <b>Negro</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>12/23/19</b>		9. AGE (In years last birthday) <b>51</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>American Smelting</b>				11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Owen Rodgers</b>				14. MOTHER'S MAIDEN NAME <b>Julia Bayer</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 11/19/42 - 2/8/46</b>				16. SOCIAL SECURITY NO. <b>218-10-14-24</b>		17. INFORMANT <b>Mrs. Genell Rodgers 407 N. Denison St.</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cerebral damage</b> <b>Pneumonia</b> <b>Carcinoma of esophagus</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Carcinoma of esophagus</b>							
19A. DATE OF OPERATION <b>12-22-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of esophagus</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (h) (this hospital) attended the deceased from <b>December 2nd 1970</b> to <b>December 29th 1970</b> that (I) (we) last saw the deceased alive on <b>December 29th 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (h) (We) (did/did not) view the body after death.							
23A. SIGNATURE <b>Donald H. Hooker</b>				23B. DATE SIGNED <b>12/30/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>DONALD H. HOOKER, M.D.</b>				23D. ADDRESS <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-4-1971</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>NUTTER FUNERAL HOME 3035 W. NORTH AVE</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

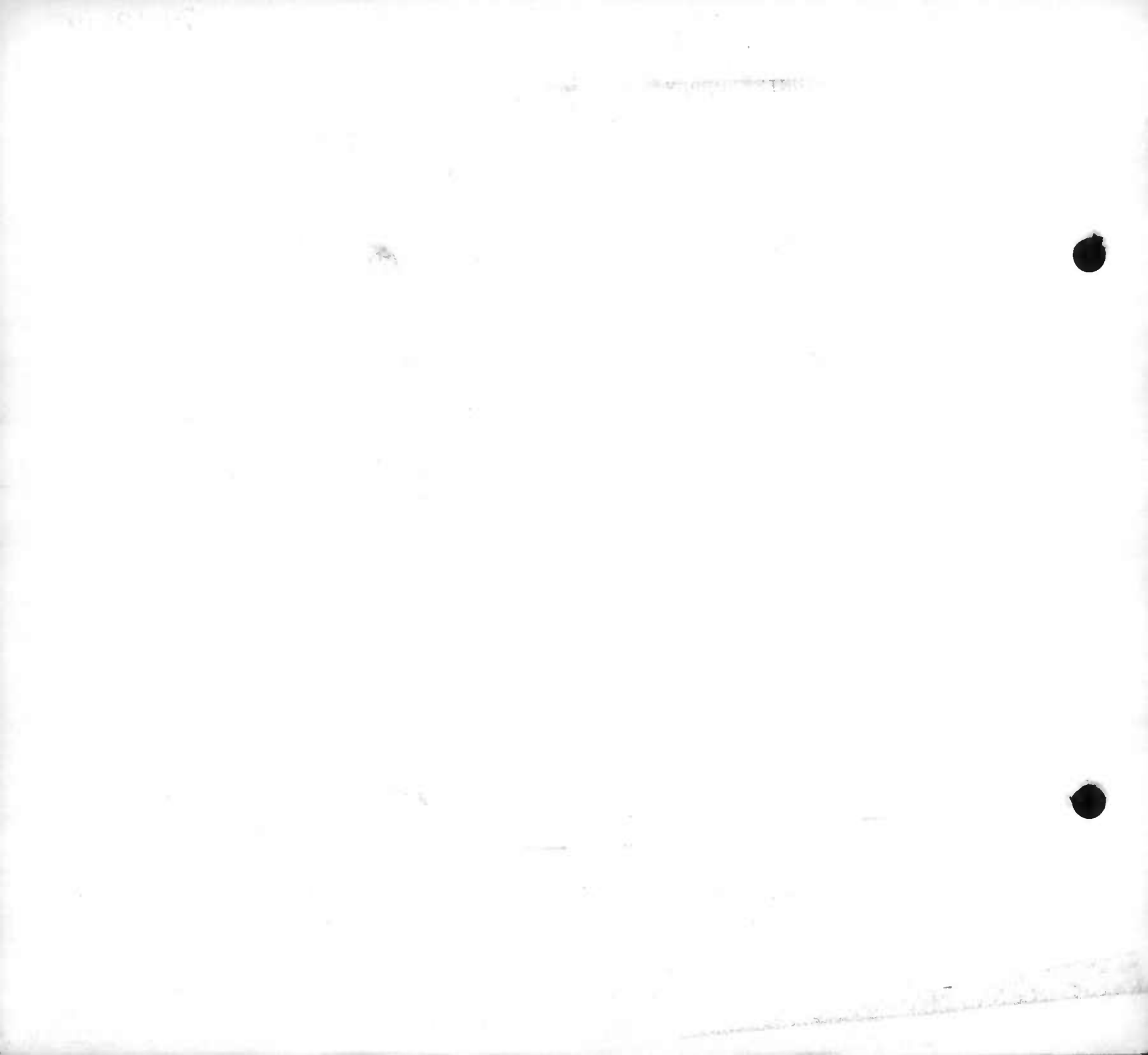
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">70 12841</span>	
BIRTH NO. <span style="font-size: 1.5em;">B-346</span>				70 12841	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
<span style="font-size: 1.2em;">Nettie M. Butler</span>			<span style="font-size: 1.2em;">12-30-70</span> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
<span style="font-size: 1.2em;">Union Memorial Hospital DOA</span>			<span style="font-size: 1.2em;">Maryland</span>		
5. SEX 6. RACE			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
<span style="font-size: 1.2em;">Female</span>		<span style="font-size: 1.2em;">Negro</span>	<span style="font-size: 1.2em;">Baltimore</span>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
<span style="font-size: 1.2em;">Domestic</span>		<span style="font-size: 1.2em;">4-2-21</span>		<span style="font-size: 1.2em;">49</span>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<span style="font-size: 1.2em;">Pvt. Family</span>		<span style="font-size: 1.2em;">Baltimore, Maryland</span>		<span style="font-size: 1.2em;">USA</span>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
<span style="font-size: 1.2em;">Spencer Johnson</span>			<span style="font-size: 1.2em;">Rose Butler</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
<span style="font-size: 1.2em;">No</span>			<span style="font-size: 1.2em;">215-16-6164</span>		<span style="font-size: 1.2em;">Frances Mohorn 1243 Sheridan Ave.</span>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			<span style="font-size: 1.2em;">Cerebral hemorrhage</span>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <span style="font-size: 1.2em;">Malignant hypertension</span>		
(C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<span style="font-size: 1.2em;">NO</span>		<span style="font-size: 1.2em;">NO</span>		<span style="font-size: 1.2em;">NO</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<span style="font-size: 1.2em;">NO</span>		<span style="font-size: 1.2em;">NO</span>		<span style="font-size: 1.2em;">NO</span>	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
<span style="font-size: 1.2em;">NO</span>		<span style="font-size: 1.2em;">NO</span>		<span style="font-size: 1.2em;">NO</span>	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">NOV. 1970</span> to <span style="font-size: 1.2em;">DEC. 14 1970</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">DEC. 14 1970</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<span style="font-size: 1.2em;">Keiffer J. Mitchell</span>				<span style="font-size: 1.2em;">1/5/71</span>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
<span style="font-size: 1.2em;">Keiffer J. Mitchell M.D.</span>				<span style="font-size: 1.2em;">2010 Hillenwood Road</span>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<span style="font-size: 1.2em;">Burial</span>		<span style="font-size: 1.2em;">1-5-71</span>		<span style="font-size: 1.2em;">Arbutus Memorial Park</span>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<span style="font-size: 1.2em;">JAN 5 1971</span>		<span style="font-size: 1.2em;">Nutter Funeral Home</span>		<span style="font-size: 1.2em;">3035-37 W. North</span>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				70 12842		70 12842	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>MINNIE MURPHY</b>				2. DATE AND HOUR OF DEATH <b>12-29-70 8:15 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI</b>				A. STATE <b>Maryland</b>		B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3007 Gwynns Falls PKWY</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-12-1903</b>	9. AGE (in years last birthday) <b>67</b>	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 1 Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>custodian</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Paint Company</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Gee</b>				14. MOTHER'S MAIDEN NAME <b>Hettie Bates</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mr. George Murphy 3007 Gwynns Falls Pk</b>			
18. CAUSE OF DEATH <b>4-12-31</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Artery Disease</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary Artery Disease</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____				_____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>this</del> (this hospital) attended the deceased from <b>12-25</b> 19 <b>70</b> to <b>12-29</b> 19 <b>70</b> that (I) <del>last</del> saw the deceased alive on <b>12-29</b> 19 <b>70</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did not) view the body after death.							
23A. SIGNATURE <b>Ralph Epstein</b>				23B. DATE SIGNED <b>12-29-70</b>		23C. PHYSICIAN'S NAME (Type) <b>DEGREE</b>	
23D. ADDRESS <b>DEGREE</b>				23E. FUNERAL DIRECTOR'S ADDRESS <b>NUTTER FUNERAL HOME 3035 W. NORTH AVE.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1-5-1971</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Carver Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Laurel Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR'S ADDRESS <b>NUTTER FUNERAL HOME 3035 W. NORTH AVE.</b>			



# FUNERAL DIRECTOR: IMPORTANT

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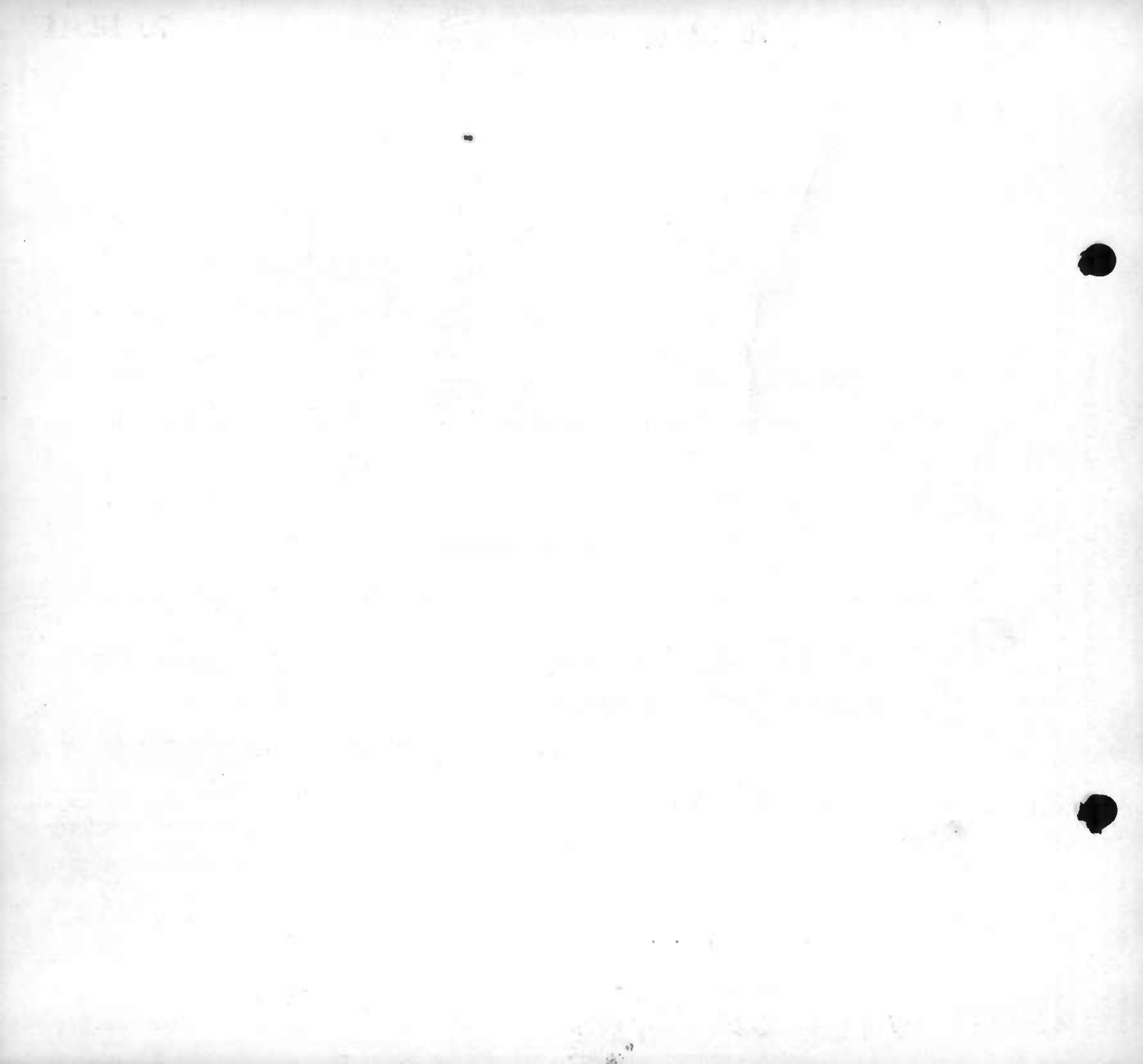
70 12843 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 12843	
BIRTH NO. <u>B-652</u>		1. NAME OF DECEASED (Type or Print) <u>IRENE BARNES</u>		2. DATE AND HOUR OF DEATH <u>12/29/70</u> <u>8:15 A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1239 Myrtle Ave</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/15/06</u>	9. AGE (In years last birthday) <u>64</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Savannah, Georgia</u>	
13. FATHER'S NAME <u>John T. Barnes</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-14-2115</u>		17. INFORMANT <u>Miss Enobia Barnes 531 Flushing Ave.</u> ADDRESS <u>Apt. 5 Brooklyn N.Y.</u>	
18. <u>427.0 17162.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Recurrent Pulmonary Emboli</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Congestive heart failure</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Metastatic lung Cancer 1 1/2 yrs. mos.</u>		
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>12/19</u> 19 <u>70</u> to <u>12/29</u> 19 <u>70</u> that (1) (we) last saw the deceased alive on <u>12/28</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Alan Steinberg MD</u>			23B. DATE SIGNED <u>12/29/70</u>		
23C. PHYSICIAN'S NAME (Type) <u>ALAN STEINBERG MD</u>			23D. ADDRESS <u>SINAI HOSP</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-30-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. (State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Bailey</u>		25C. FUNERAL DIRECTOR <u>Mary-Elizabeth Law</u> ADDRESS <u>802 Madison Ave.</u>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
N-350 70 12844		70 12844			
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
ROBINETTE MALE NEWTON		Dec. 23, 1970			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
oo 3905 CHATHAM ROAD				A. STATE B. COUNTY	
		MARYLAND			
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3905 CHATHAM ROAD		1510	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FEMALE	COLORED	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 1, 1912	58	Teacher
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
		Baltimore City		Baltimore, Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
PETER F. MALE		MAUDE ALLEN		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				W. HARRY NEWTON - 3905 CHATHAM ROAD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		ovarian Carcinoma, metastatic		6 yrs +	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1966 to Dec 23 1970, that (I) (we) last saw the deceased alive on Dec 11 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Daniel Bakal		12-28-70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Daniel Bakal, M.D.		3600 Lockwood Dr 21207			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		12-29-70		New Cathedral Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 5 1971		Robert E. Taylor		Mary-Elizabeth Law 802 Madison Ave.	



FUNERAL DIRECTOR: IMPORTANT

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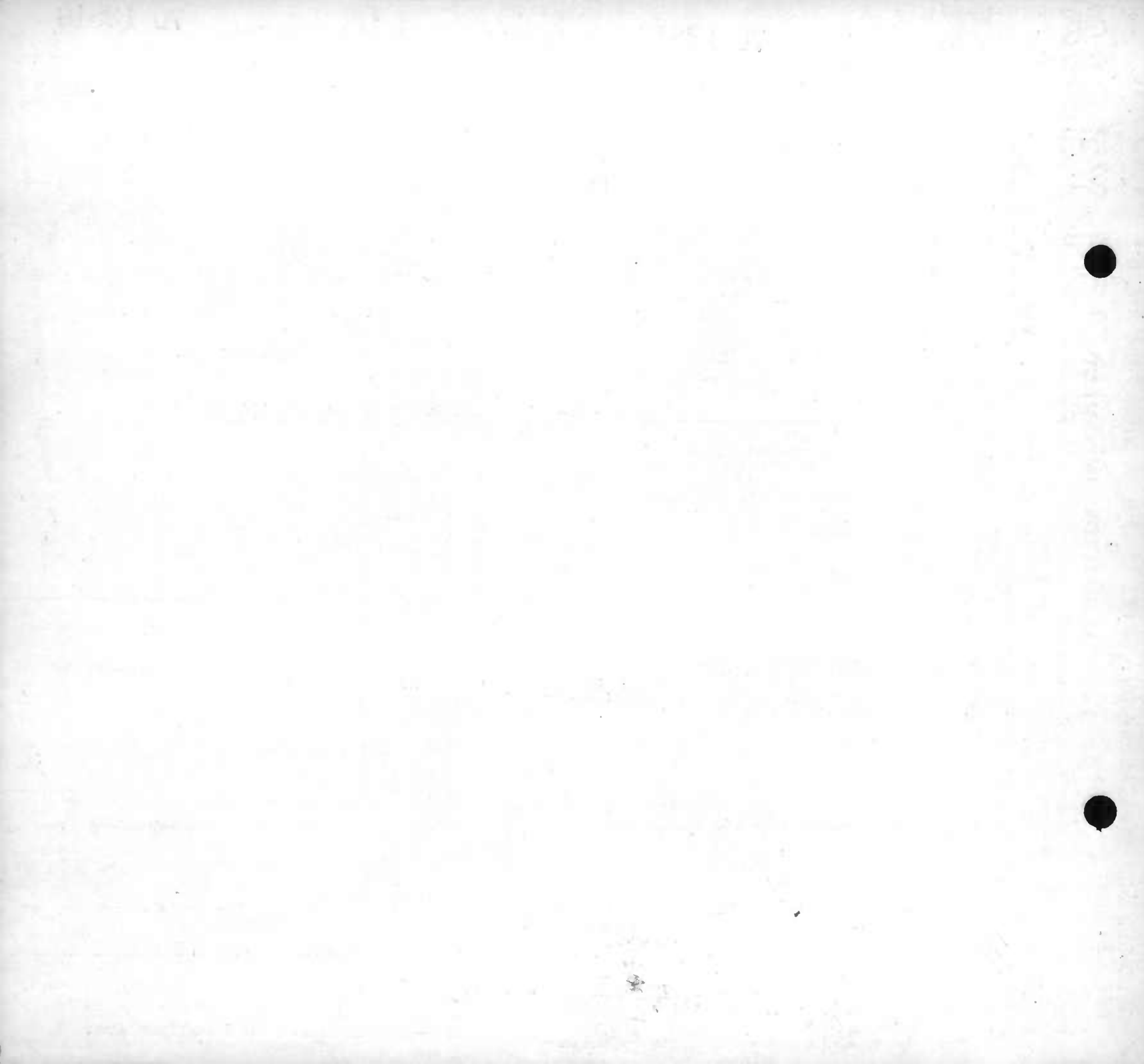
BALTIMORE CITY HEALTH DEPARTMENT				70 12845	
W-325 70 12845				REG. NO. 70 12845	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>ELIZABETH WATKINS</b>			2. DATE AND HOUR OF DEATH <b>12-25-70 5<sup>45</sup> P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 SINAI HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5357 DENMORE AVE 2788</b>		
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-19-24</b>	9. AGE (in years last birthday) <b>46</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <b>Surry, Va.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>William H. Brown</b>			14. MOTHER'S MAIDEN NAME <b>Viana Smith</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>216-24-4642</b>		
17. INFORMANT <b>Mr. Percy Watkins</b>			ADDRESS <b>5357 Denmore Ave.</b>		
18. <b>403X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A). (A) IMMEDIATE CAUSE <b>HYPERTENSION</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>NEPHROSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>RENAL FAILURE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>12-16-70</b> 19 to <b>12-25</b> 19 <b>70</b> that (I) ( <del>was</del> ) last saw the deceased alive on <b>12-25</b> 19 <b>70</b> and that in (my) ( <del>my</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Ralph Epstein MD</b>				23B. DATE SIGNED <b>12-25-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>RALPH EPSTEIN MD</b>				23D. ADDRESS <b>SINAI HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-29-70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>7 Mt. Calvary</b>	
24D. LOCATION <b>Baltimore Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1971</b>			
25B. NAME OF REGISTRAR <b>246 E. Taylor St.</b>		25C. FUNERAL DIRECTOR <b>Mary-Elizabeth Law</b>			
25D. ADDRESS <b>802 Madison Ave.</b>					



**FUNERAL DIRECTOR: IMPORTANT**

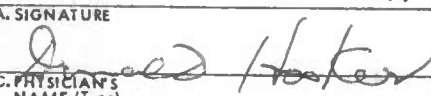
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

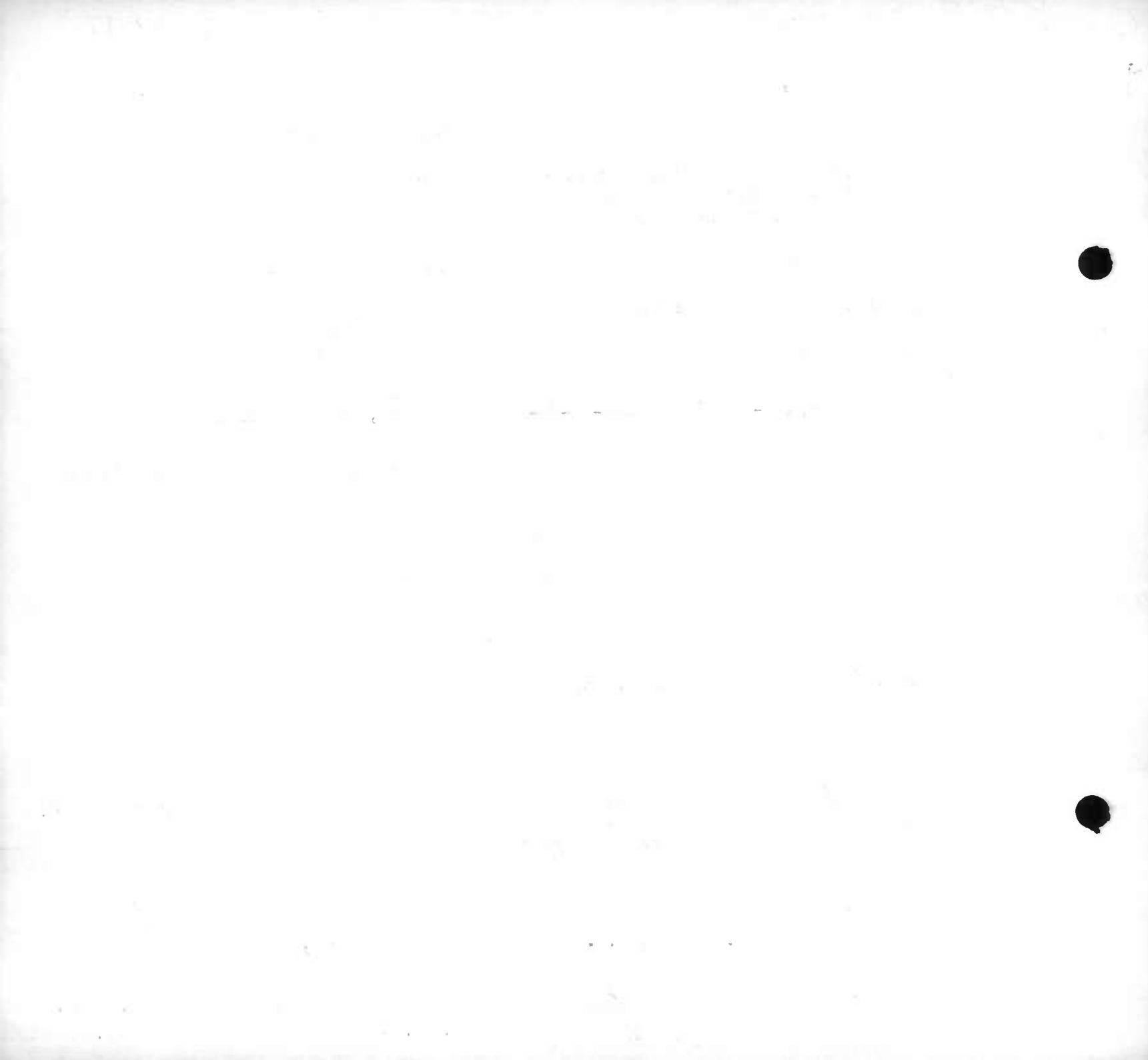
T-520 70 12846		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 70 12846	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>LULA TOWNES</b>		2. DATE AND HOUR OF DEATH <b>12-26-70 12.05 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 THE JOHNS HOPKINS HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>4722 ALHAMBRA AVE 2710</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-13-05</b>	9. AGE (In years lost birthday) <b>65</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOSPITAL WORKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>UNIVERSITY HOSPITAL</b>		11. BIRTHPLACE (State or foreign country) <b>TILLERY N.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>RICHARD CLARK</b>		14. MOTHER'S MAIDEN NAME <b>MARSHANN JOHNSON</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-14-5868</b>		17. INFORMANT ADDRESS <b>MR. HAYWARD DEMARY 1311 SILVERTHORNE RD.</b>	
18. <b>18201</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>CARDIO RESPIRATORY INSUFFICIENCY</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>TERMINAL STAGE OF ENDOMETRIAL CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <i>[Signature]</i>		23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-31-70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>	
24D. LOCATION <b>BALTIMORE MD.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1971</b>		24F. NAME OF REGISTRAR <b>MARY-ELIZABETH LAW</b>	
24G. ADDRESS <b>802 Madison Ave.</b>		24H. NAME OF REGISTRAR <b>MARY-ELIZABETH LAW</b>		24I. ADDRESS <b>802 Madison Ave.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

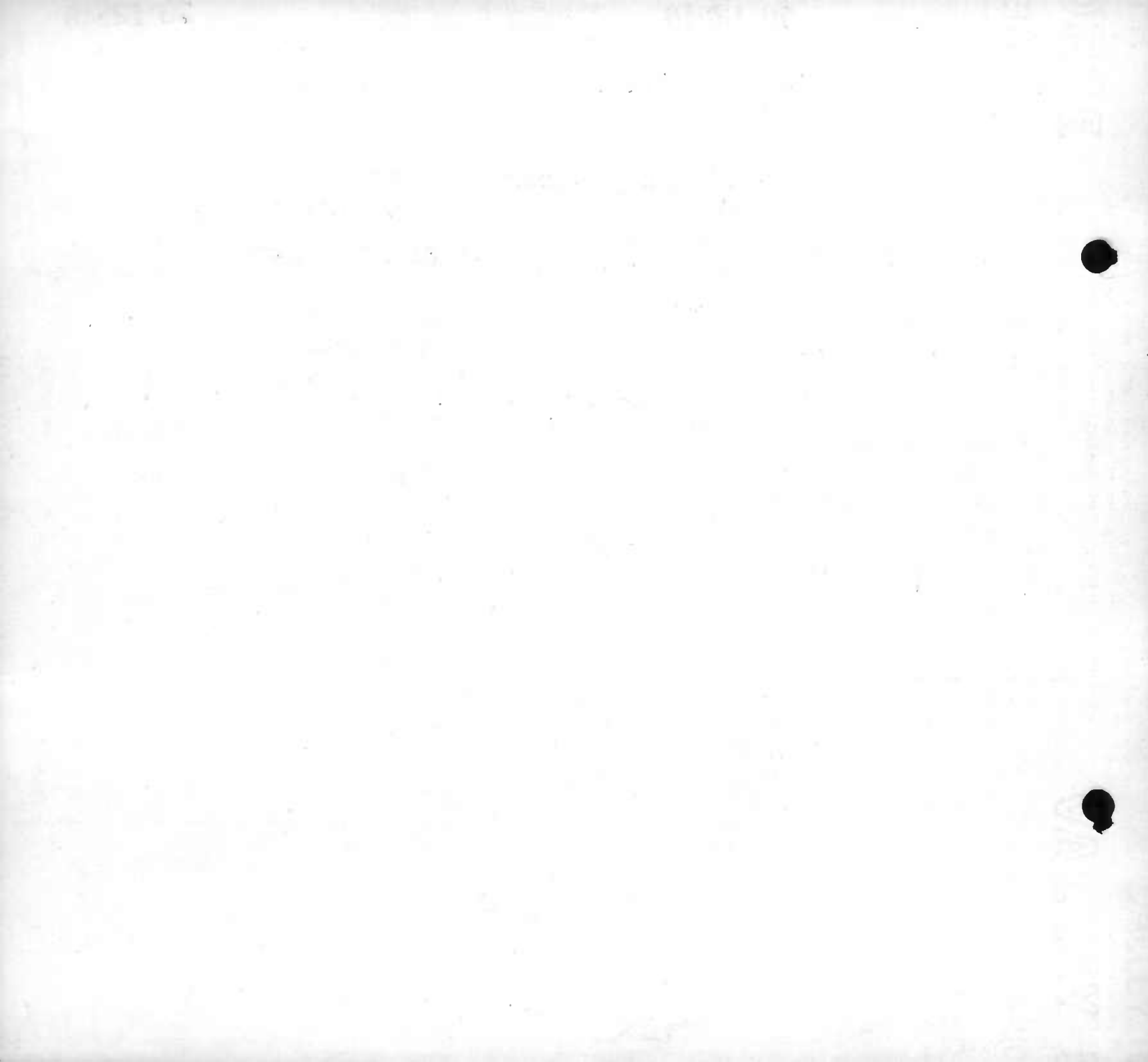
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 12847
1. NAME OF DECEASED (Type or Print) <b>GREEN, AUGUSTINE</b>		2. DATE AND HOUR OF DEATH <b>12/30/70 4:15 A</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Queen Anne</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>		C. CITY OR TOWN <b>Chester</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER				
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/11/88</b>	9. AGE (In years last birthday) <b>82</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>sea food</b>		11. BIRTHPLACE (State or foreign country) <b>Chester Md</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Frank Green</b>		14. MOTHER'S MAIDEN NAME <b>Julia Sanders</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 6/19/18 - 7/8/19</b>		16. SOCIAL SECURITY NO. <b>219-01-08-93</b>		17. INFORMANT <b>VA Hospital Records Baltimore, Maryland 21218</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Cardiac arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>Sepsis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Decubitis ulcers</b> (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Chronic brain syndrome and uremia</b>				
19A. DATE OF OPERATION <b>11/25/70</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Decubitis ulcers</b>	20A. AUTOPSY? (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>November 20th 19 70</b> to <b>December 30th 19 70</b> that (I) (we) last saw the deceased alive on <b>December 30th 19 70</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. <b>W</b> (We) (did) (did not) view the body after death.				
23A. SIGNATURE 		23B. DATE SIGNED <b>12/30/70</b>		
23C. PHYSICIAN'S NAME (Type) <b>DONALD H. HOOKER, M.D.</b>		23D. ADDRESS <b>3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1/2/71</b>	24C. NAME OF CEMETERY OR CREMATORY <b>John Westley</b>	24D. LOCATION (City, town, or county) (State) <b>Chester, Maryland Queen Anne Co.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1971</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR <b>J. B. Dashiell 426 Dover St. Easton</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12848	
<b>BIRTH NO.</b> 1. NAME OF DECEASED (Type or Print) <u>Steeple, Matthew</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>12-31-70</u> <u>4:45</u> P.M.			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION <u>33</u> <b>JOHNS HOPKINS HOSPITAL</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		<b>4. USUAL RESIDENCE</b> (Where deceased lived, If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Balto</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3901 BOARMAN AVE.</u> <u>1510</u>			
<b>5. SEX</b> <u>M</u>	<b>6. RACE</b> <u>N</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>6-03-05</u>	<b>9. AGE</b> (In years lost birthday) <u>65</u>	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>Balto. Gas &amp; Elec</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Stevenson Co. Ga.</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>
<b>13. FATHER'S NAME</b> <u>FRANK STEEPLE</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>HALEY PATTERSON</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>212-05-3472</u>		<b>17. INFORMANT</b> <u>3901 Boarman Avenue</u> ADDRESS <u>Adelaide Davis</u>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the made of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>Prostatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF:  (C)		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <u>30 min.</u>  <u>1 1/2 yrs</u>	
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
<b>19A. DATE OF OPERATION</b> <u>2</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <u>yes</u>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>12/31</u> <b>19</b> <u>70</u> <b>to</b> <u>12/31</u> <b>19</b> <u>70</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>12/31</u> <b>19</b> <u>70</u> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>Peter Densen MD</u>				<b>23B. DATE SIGNED</b> <u>12/31/70</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>Peter Densen MD</u>		<b>23D. ADDRESS</b> <u>601 N. Broadway; Balto. MD.</u>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>24B. DATE</b> <u>1-5-71</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>Mt. Calvary Cemetery</u>	
<b>24D. LOCATION</b> (City, town, or county) (State) <u>A.A. Co, Maryland</u>		<b>24E. FUNERAL DIRECTOR</b> <u>735 Harford Ave. 21215</u> <u>Marshall W. Jones, Jr.</u>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>W. RICHARD HOLEMAN</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>48 MARYLAND GENERAL HOSPITAL</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 31, 1970 10:30 P.M.</b>			
6. SEX <b>Male</b>				7. RACE <b>Negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>11-6-1932</b>				10. AGE (In years last birthday) <b>38</b>		11. BIRTHPLACE (State or foreign country) <b>Halifax Co., Virginia</b>	
12. CITIZEN OF <b>U.S.A.</b>				13. FATHER'S NAME <b>Benjamin Holeman</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
15. MOTHER'S MAIDEN NAME <b>Lillie Holeman</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes. 7/9/52 6/19/54</b>			
17. SOCIAL SECURITY NO. <b>230-34-5039</b>				18. INFORMANT <b>Mrs. Elizabeth Stovall</b>			
19. <b>E 9291 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				CAUSE OF DEATH <b>Subdural Hematoma</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)			
20. DATE OF OPERATION <b>2</b>				21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Bethlehem Steel, Sparrows Point</b>			
22C. WHERE DID INJURY OCCUR? <b>Bethlehem Steel, Sparrows Point</b>				22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY <b>12-24-70 P. 4</b>			
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR? <b>Subject collapsed at work</b>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED <b>1/1/71</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-4-71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Zion Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Mayo, Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1971</b>		25B. NAME OF REGISTRAR <b>0 0 0 2</b>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens St.</b>	

101510

101510

11-1933

11-1933

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-425 70 12850		BALTIMORE CITY HEALTH DEPARTMENT		70 12850	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>FRANK I. NELSON</b>			2. DATE AND HOUR OF DEATH <b>DEC 30, 1970 6:15 P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>34 BON SECURE Hospital</b>			C. CITY OR TOWN <b>BALTO.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>2125 PENROSE</b>		ROSE <b>Box 2082</b>
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/6/23</b>	9. AGE (In years last birthday) <b>47</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction worker</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>S. Carolina, Georgetown</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Robert I. Nelson</b>			14. MOTHER'S MAIDEN NAME <b>Lurenia Smith</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO.</b>		16. SOCIAL SECURITY NO. <b>248-22-1644</b>		17. INFORMANT <b>Mrs. Meter Nelson</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>5-82X</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>CVA</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Chronic Renal Disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>less than (72) hrs. + week</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 27</b> 19 <b>70</b> to <b>Dec 30</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>Dec 30</b> 19 <b>70</b> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Rolando M. Sabanero</b>				23B. DATE SIGNED <b>12-30-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>ROLANDO M. SABANERO</b>				23D. ADDRESS <b>Bon Secours Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/4/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Family Lot</b>	
24D. LOCATION (City, town, or county) (State) <b>Georgetown, South Carolina</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 5 1971</b>			
25B. NAME OF REGISTRAR <b>Morton E. Dyett F.H.</b>		25C. FUNERAL DIRECTOR <b>1701 Laurens St.</b>			



BIRTH NO.		REG. NO.	
8-534 70 12851		70 12851	
1. NAME OF DECEASED (Type or Print) Rev. JOSEPH RANDOLPH		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION PROVIDENT HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour December 9, 1970 3:45 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 7-14-1904		10. AGE (in years last birthday) 66	
11. BIRTHPLACE (State or foreign country) Scottsville, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs. Marie E. Branham		ADDRESS Brooklyn, N.Y. 60 Kingsland Ave	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E8901X		CAUSE OF DEATH Smoke and Soot Inhalation Incident to Conflagration (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1314 Druid Hill Avenue	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12-9-70 3:20 A.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Subject in house fire		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		DATE SIGNED 12/9/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-9-71	
24C. NAME OF CEMETERY or CREMATORY Evergreen Cemetery		24D. LOCATION (City, town, or county) (State) Brooklyn, New York	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1971		25B. NAME OF REGISTRAR MORTON E. DYETT F.H.	
25C. FUNERAL DIRECTOR ADDRESS 1701 Laurens Street		1702	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12852</u>	
BIRTH NO. <u>S-164</u>		70 12852		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Spruelli, Walter (XXXX)</u>			2. DATE AND HOUR OF DEATH <u>12/31/70</u> <u>9 30/P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lincoln Memorial Nursing Home</u>			A. STATE <u>Maryland</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>27 N. Carey St. Balt. Md.</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Male</u>			6. RACE <u>negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH <u>1/10/00</u>			9. AGE (In years last birthday) <u>70</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>
11. BIRTHPLACE (State or foreign country) <u>Petersburg, Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>unknown (Theopolis Spruelli)</u>			14. MOTHER'S MAIDEN NAME <u>Ella Tanner</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>			16. SOCIAL SECURITY NO. <u>213-07-7887</u>		17. INFORMANT <u>Mrs. Mayolla Spruelli</u>
18. CAUSE OF DEATH <u>C.V.A.</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION <u>5/11/74</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/11/74</u> to <u>12/31/70</u> and that (I) (we) last saw the deceased alive on <u>12/31/70</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harris</u>			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) <u>DEANALINE</u>			23D. ADDRESS <u>1801 GREENBERRY Rd Pkts, Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-5-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Cemetery</u>	
24D. LOCATION <u>Randallstown, Maryland</u>		25A. DATE RECD BY HEALTH DEPT. <u>JAN 5 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Morton + Dyett</u>			
25D. ADDRESS <u>1701 LAWRENCE ST</u>					

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12853</u>	
BIRTH NO. <u>H-354</u>		70 12853		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>MARY HUDNELL</u>			2. DATE AND HOUR OF DEATH <u>December 31, 1970</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1319 W. Mosher Street</u>			4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1319 W. Mosher Street</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-12-1902</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Unk.</u>		
14. MOTHER'S MAIDEN NAME <u>Unk.</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mr. Howard Hudnell 1319 W. Mosher St.</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Coronary Heart Disease</u> <u>Myocarditis, Congestive Heart Failure</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Hepatomegaly of unknown etiology</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u> <u>3 1/2 years</u> <u>3 1/2 years</u>					
19A. DATE OF OPERATION <u>9-11-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>9-11</u> <u>1967</u> to <u>12-18</u> <u>1970</u> that (1) (we) last saw the deceased alive on <u>12-18</u> <u>1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Samuel R. Owings, Jr., M.D.</u>				23B. DATE SIGNED <u>1-4-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>SAMUEL R. OWINGS, JR. M.D.</u>		23D. ADDRESS <u>909 N. Carey Street</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-7-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Mount Auburn Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1971</u>			
25B. NAME OF REGISTRAR <u>John E. Jaber, M.D.</u>		25C. FUNERAL DIRECTOR <u>MORTON &amp; DYETT F.H.</u>			
25D. ADDRESS <u>1701 Laurens Street</u>					

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12854</u>
BIRTH NO. <u>70 12854</u>		1. NAME OF DECEASED (Type or Print) <u>Francois KERLEY</u>		
2. DATE AND HOUR OF DEATH <u>12/26/70</u> <u>2:50</u> P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY _____		
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTIMORE</u> <u>42</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>4103 Sunnyside Ave</u>		<u>228131</u>		
5. SEX <u>F</u>	6. RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>SEP</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/11/1928</u>	9. AGE (In years last birthday) <u>42</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Victorian</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Key</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>William Kemp</u>		
14. MOTHER'S MAIDEN NAME <u>Sally Roman</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		
16. SOCIAL SECURITY NO. <u>404-16-3065A</u>		17. INFORMANT <u>Mr. Karl Hausmann</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>412.412.250.9</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>Cerebro Vascular Acc.</u>		
ANTECEDENT CAUSES		(B) <u>ASCVD</u>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes mellitus</u>				
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (1) (this hospital) attended the deceased from <u>December 22 1970</u> to <u>Dec 26 1970</u> that (2) (we) lost saw the deceased alive on <u>Dec 26 1970</u> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death.				
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>12/26/70</u>		
23C. PHYSICIAN'S NAME (Type) <u>PUG-ANTICH</u>		23D. ADDRESS <u>Sun Hup.</u>		
24A. BURIAL CREMATION REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Dec 29 1970</u>	<u>Woodlawn Ridge Cemetery</u>	<u>Pikesville</u>	<u>Baltimore Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1971</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	25C. FUNERAL DIRECTOR <u>Frank H. Newell</u>		

NO 15824

NO 15824

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525		70 12855		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12855	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>ROLAND JOHNSON</u>				2. DATE AND HOUR OF DEATH <u>12-31-70</u> <u>2:25 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MARYLAND</u>		B. COUNTY	
<u>43 SOUTH BALTO. GEN. HOSPITAL</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>				6. RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>4-21-17</u>	
<u>NONE</u>				<u>NONE</u>		9. AGE (in years last birthday) <u>53</u>	
13. FATHER'S NAME <u>LEON WEEKS</u>				14. MOTHER'S MAIDEN NAME <u>PEARL STOKES</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>BERNICE GREEN - SISTER</u>	
18. <u>492X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute myocardial infarction</u>			
				(B) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <u>Emphysema</u>			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
<input type="checkbox"/>							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <u>12-29</u> 19 <u>70</u> to <u>12-31</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>12-31</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Lilia B. Villafania M.D.</u>				23B. DATE SIGNED <u>12-31-70</u>			
23C. PHYSICIAN'S NAME (Type) <u>LILIA B. VILLAFANIA M.D.</u>				23D. ADDRESS <u>SOUTH BALTO. GEN. HOSP.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 6/71</u>		<u>Mt. Auburn</u>		<u>Baltimore Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 6 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Kelly, M.D.</u>		25C. FUNERAL DIRECTOR'S ADDRESS <u>V. Brooks Funggold 14637 N. Carey</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
70 12856 CERTIFICATE OF DEATH					REG. NO. 70 12856					
1. NAME OF DECEASED (Type or Print) <b>STRACHAN MRS. GERTRUDE W.</b>					2. DATE AND HOUR OF DEATH <b>DEC. 29 1970 3 A M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>BON SECOURS HOSPITAL</b>					4. USUAL RESIDENCE (where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b>					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BON SECOURS HOSPITAL</b>					C. CITY OR TOWN <b>ESSEX</b> <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
					E. STREET AND NUMBER <b>842 Brunswick Rd. 52122</b>					
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 4 1890</b>		9. AGE (in years last birthday) <b>80</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES LADY</b>					10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>										
13. FATHER'S NAME <b>WM H. DIETERLY</b>					14. MOTHER'S MAIDEN NAME <b>KATE BUTTS</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>					16. SOCIAL SECURITY NO. <b>012-03-5673</b>		17. INFORMANT <b>HOSPITAL CHART</b>			
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Congestive heart failure</b> (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>chronic + acute years</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).										
19A. DATE OF OPERATION <b>12-26-70</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>INTESTINAL OBST.</b>			20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>no</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <b>no</b>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>no</b>			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>12-16-70</b> 19 to <b>12-29-70</b> 19 that (I) (we) last saw the deceased alive on <b>12-28-70</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>Narciso A. De Borda M.D.</b>					23B. DATE SIGNED <b>12-29-70</b>			23C. PHYSICIAN'S NAME (Type) <b>NARCISO A. DE BORDA M.D.</b>		
23D. ADDRESS <b>BON SECOURS HOSP. BALTIMORE MD</b>										
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			24B. DATE <b>12/31/70</b>			24C. NAME OF CEMETERY OR CREMATORY <b>HOLLY HILL</b>			24D. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 6 1971</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>			25C. FUNERAL DIRECTOR <b>Connelly Funeral Home</b>				



C-242		70 12857		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 70 12857	
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) Joseph H. Czekalewski					2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 801 N. Lakewood Ave.					3. DATE PRONOUNCED DEAD Month Day Year Hour 12 29 70 11:30 am.				
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY					C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
6. SEX male		7. RACE white		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		E. STREET AND NUMBER 801 N. Lakewood Ave.			
9. DATE OF BIRTH May 5, 1927		10. AGE (In years last birthday) 43		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Boloeslaw Czekalewski		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Magdalena Gasiorowski		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes Navy WW 2 216-20-4823			
17. SOCIAL SECURITY NO.		18. INFORMANT Frances Renshaw, sister, 1531 Chilworth		19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Hypertensive cardiovascular disease		DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/29/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/4/71		24C. NAME of CEMETERY or CREMATORY Gettysburg Nat. Cem.		24D. LOCATION (City, town, or county) (State) Gettysburg, Pa.			
25A. DATE REC'D BY HEALTH DEPT. JAN 6 1971		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 2601 E. Madison Street			



BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)MORRIS  
EDWARD M. NOONAN2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

December 31, 1970

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3047 Gilford Street

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

December 31, 1970

11:10 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland 21218

1702

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

2/26/20

10. AGE (In years  
lost birthday)

50

11 Under 1 Yr. 12 Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

3047 Gilford Street Ave

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

Edward J. Noonan

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Julia A. Whitty

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL  
SECURITY NO.

18. INFORMANT 827 Exeter Hall ADDRESS 21218

Catherine Williams, sister,

19. 412.4

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME  
OF INJURY  
(APPROX.)

(Month)

(Day)

(Year)

(Hour)

22E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Charles S. Springate, M.D.

EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 31, 1970

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1/4/71

24C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 6 1971

25B. NAME OF REGISTRAR

Charles S. Springate, M.D.

25C. FUNERAL DIRECTOR

Schmunk Funeral Home Inc.

3331 Brehms Lane

70 15-28

70 15-28

MINORCA 27-11-1958

70 15-28

Name		Age		Sex		Occupation		Address		Remarks	
J. J. J.		25		M		Teacher		123 Main St.		Single	
M. J. J.		30		F		Homemaker		456 Oak St.		Married	
A. J. J.		40		M		Engineer		789 Pine St.		Married	
B. J. J.		20		M		Student		321 Elm St.		Single	
C. J. J.		35		F		Nurse		654 Maple St.		Married	
D. J. J.		45		M		Doctor		987 Birch St.		Married	
E. J. J.		28		F		Teacher		101 Cedar St.		Single	
F. J. J.		38		M		Engineer		202 Elm St.		Married	
G. J. J.		22		M		Student		303 Pine St.		Single	
H. J. J.		32		F		Homemaker		404 Oak St.		Married	
I. J. J.		42		M		Engineer		505 Maple St.		Married	
J. J. J.		27		F		Teacher		606 Birch St.		Single	
K. J. J.		37		M		Engineer		707 Cedar St.		Married	
L. J. J.		23		M		Student		808 Elm St.		Single	
M. J. J.		33		F		Homemaker		909 Pine St.		Married	
N. J. J.		43		M		Engineer		1010 Oak St.		Married	
O. J. J.		24		M		Student		1111 Maple St.		Single	
P. J. J.		34		F		Homemaker		1212 Birch St.		Married	
Q. J. J.		44		M		Engineer		1313 Cedar St.		Married	
R. J. J.		26		M		Student		1414 Elm St.		Single	
S. J. J.		36		F		Homemaker		1515 Pine St.		Married	
T. J. J.		46		M		Engineer		1616 Oak St.		Married	
U. J. J.		21		M		Student		1717 Maple St.		Single	
V. J. J.		31		F		Homemaker		1818 Birch St.		Married	
W. J. J.		41		M		Engineer		1919 Cedar St.		Married	
X. J. J.		29		M		Student		2020 Elm St.		Single	
Y. J. J.		39		F		Homemaker		2121 Pine St.		Married	
Z. J. J.		49		M		Engineer		2222 Oak St.		Married	

ACADEMY RECORD

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12859	
<div style="text-align: center;"> <b>S-362</b>  <b>CERTIFICATE OF DEATH</b> </div>					
BIRTH NO.		1. NAME OF DECEASED <b>STREJCEK</b>		2. DATE AND HOUR OF DEATH <b>12-31-70 11:45 A.M.</b>	
(Type or Print) <b>Strejcek, Frances</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE <b>Maryland</b>		
<b>The Johns Hopkins Hospital</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>
			E. STREET AND NUMBER <b>423 N. Duncan Street</b>		<b>603</b>
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/17/96</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Denton, Md.</b>	
13. FATHER'S NAME <b>Frank Griffith</b>		14. MOTHER'S MAIDEN NAME <b>Salley Bradley</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>21237 Anna Bures, neice, 524 Pa tapsco Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Renal failure</b>		<b>4 days</b>	
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF: <b>GI bleeding, 2° Stress ulcer, 2° pneumonia, pulmonary edema</b>		<b>6 days</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>2° hip fracture</b>		<b>12 days</b>	
		(C) <b>Chronic debilitation</b>		<b>3 weeks</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>12-11-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>hip fracture</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Pt's home; blown over by wind</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>12-7-70</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>and fractured hip</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>12-7</b> 19 <b>70</b> to <b>12-31</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>12-31</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Bruce A. Reitz, M.D.</b>				23B. DATE SIGNED <b>12-31-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>BRUCE A. REITZ, M.D.</b>				23D. ADDRESS <b>Johns Hopkins Hosp., BALTO, MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/4/71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery, Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 6 1971</b>		25B. NAME OF REGISTRAR <b>John E. J. J.</b>		25C. FUNERAL DIRECTOR <b>Schimmek Funeral Home, Inc. 2601 E. Madison St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-400		70 12860		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12860	
1. NAME OF DECEASED (Type or Print) <b>KELLY, JAMES EDWARD J.</b>				2. DATE AND HOUR OF DEATH <b>December 31, 1970 6:30 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b> 6. RACE <b>Caucasian</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>1-20-1896</b>		9. AGE (in years last birthday) <b>74</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>U. S. Civil Service</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>James P. Kelly</b>			
14. MOTHER'S MAIDEN NAME <b>Anna Bell Caulk</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>Yes</b> 16. SOCIAL SECURITY NO. <b>4-10-18 to 10-2-19 PN424-01-20-96</b>			
17. INFORMANT <b>Records, V. A. Hospital</b>				18. ADDRESS <b>3900 Loch Raven Blvd., Baltimore, Md. 21218</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>RESPIRATORY FAILURE</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma of Base of tongue, metastatic to neck and lungs</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>1-4-71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from <b>December 29, 1970</b> to <b>December 31, 1970</b> that (X) (we) last saw the deceased alive on <b>December 31, 1970</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>E C Holmes MD</b>				23B. DATE SIGNED <b>1-2-71</b>			
23C. PHYSICIAN'S NAME (Type) <b>E C HOLMES, MD</b>				23D. ADDRESS <b>VA HOSPITAL, 3900 Loch Raven Blvd Baltimore, Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-4-71</b>		24C. NAME OF CEMETERY OR CREMATOR <b>MOST HOLY REDEEMER</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 6 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Seabury, R.D.</b>		25C. FUNERAL DIRECTOR <b>J. Walter Conklin 5444 BELAIR Rd.</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-540 70 12861		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12861	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MANNEL, ANNA		2. DATE AND HOUR OF DEATH 12/30/70 3 <sup>30</sup> PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION PLEASANT MANOR NURSING HOME 4615 PARK HEIGHTS AVE BALTIMORE, MD 21215		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD - B. COUNTY BALTIMORE		C. CITY OR TOWN BALTIMORE	
5. SEX F		6. RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH JUN 14 1976		9. AGE (In years last birthday) 95		10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 554-32-6409		17. INFORMANT John H. Mannel	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction, acute (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min.			
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-29-70 to 12-30-70 that (I) (we) lost saw the deceased alive on 12-21-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frank G. Kuehn MD		23B. DATE SIGNED 12/31/70			
23C. PHYSICIAN'S NAME (Type) FRANK G. KUEHN MD		23D. ADDRESS 721 MED ARTS BLDG. BALTO 1			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/2/71		24C. NAME OF CEMETERY OR CREMATORY Western Cemetery	
24D. LOCATION Baltimore Maryland		25A. DATE RECD BY HEALTH DEPT. JAN 6 1971		25B. NAME OF REGISTRAR Ambrose Inc 1328 Sulphur Sp. Rd.	



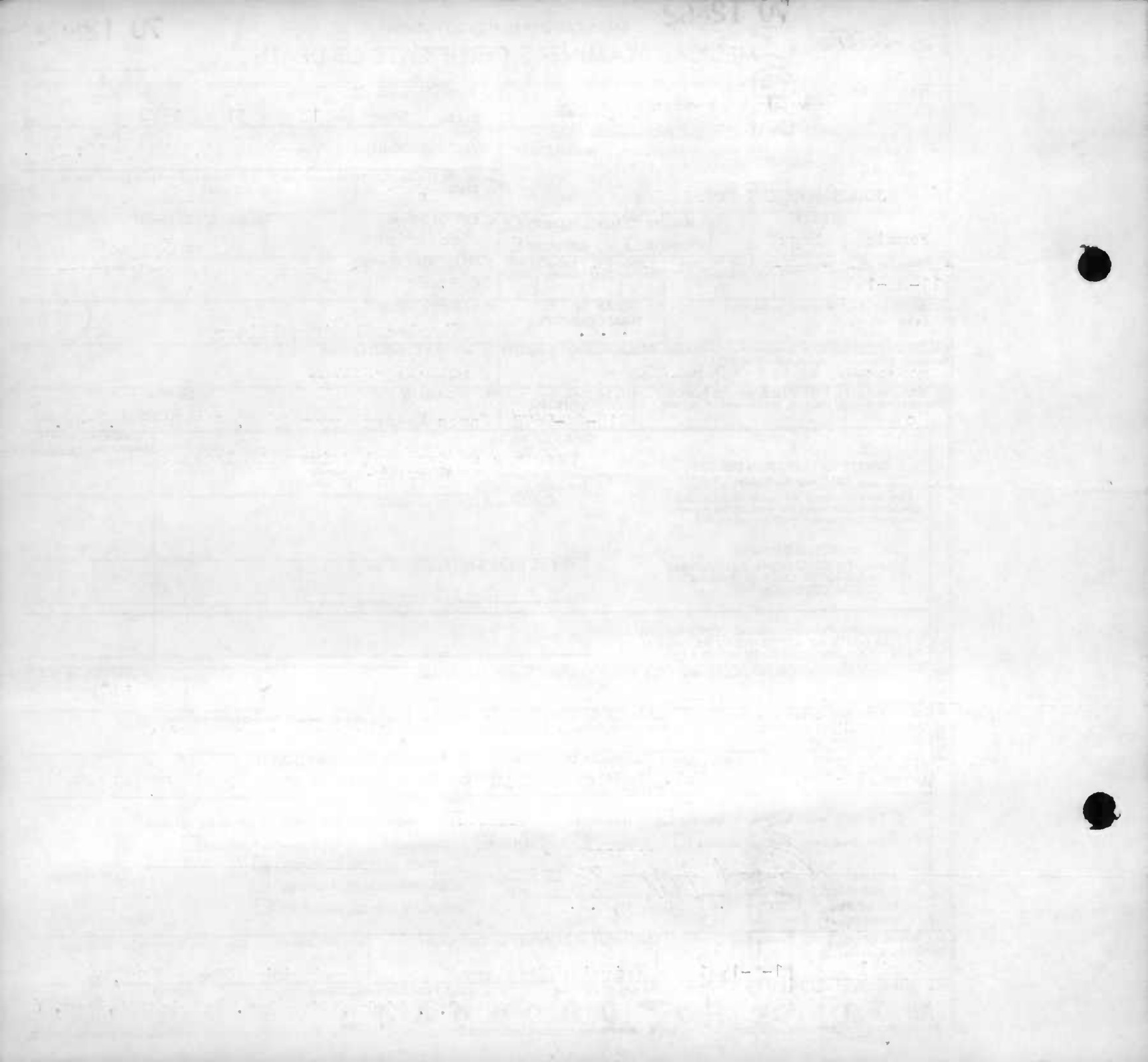
B-650 70 12862  
BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 12862

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>ELEANORE ELIZABETH BROWN</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>12</b> Day <b>31</b> Year <b>1970</b> Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month <b>December</b> Day <b>31</b> , 1970 Hour <b>11:15 P.</b> M.	
5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Frederick</b>		C. CITY OR TOWN <b>Frederick</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>Female</b>	7. RACE <b>Negro</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>11-22-1930</b>	10. AGE (In years lost birthday) <b>40</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles Eldridge Palmer</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clothing</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>	
15. MOTHER'S MAIDEN NAME <b>Harriet Summers</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>218-24-9673</b>		18. INFORMANT ADDRESS <b>James Walter Brown 26 E. 5th Street, Fred. Md</b>	
19. <b>E 814.7</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Fracture of Cervical Spine with laceration of spinal cord</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Frederick, Maryland</b>		22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.) <b>12-20-70 Unk. m.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Pedestrian struck by hit and run driver</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>1/1/71</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-5-1971</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Fairview Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Frederick Frederick, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 6 1971</b>		25B. NAME OF REGISTRAR <b>C. E. Hicks</b>	
25C. FUNERAL DIRECTOR <b>C. E. Hicks</b>		25D. ADDRESS <b>111 263 W. Patrick St, Fred. Md</b>	



D-524

70 12863

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12863

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Martin Dengler				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 12 27 70 10:20 p.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 702 N. Howard Street				3. DATE PRONOUNCED DEAD Month Day Year Hour 12 27 70 10:20 p.m.			
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md.				B. COUNTY			
6. SEX male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Feb. 5, 1917		10. AGE (in years lost birthday) 53		11. BIRTHPLACE (State or foreign country) Oberlein Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME A. Dengler		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electric welder		15. MOTHER'S MAIDEN NAME Betty Mitchell		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no none	
17. SOCIAL SECURITY NO.		18. INFORMANT A.L. Dengler-Bro.		19. ADDRESS 212 Eutaw St. Harrisburg Pa.		20. CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
21. DATE OF OPERATION		22. CONDITION FOR WHICH OPERATION WAS PERFORMED		23. AUTOPSY? (Yes or No) no		24. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	
25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		27. TIME (Month) (Day) (Year) (Hour) (Minute) (Approx.)		28. HOW DID INJURY OCCUR?	
29. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		30. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		31. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		32. ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
33. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		34. DATE 1/4/71		35. NAME OF CEMETERY or CREMATORY Paxtang Cemetery		36. LOCATION (City, town, or county) (State) Paxtang By-pass Pa.	
37. DATE REC'D BY HEALTH DEPT. JAN 6 1971		38. NAME OF REGISTRAR John E. J. [illegible]		39. FUNERAL DIRECTOR 1216 S. Charles St.		40. ADDRESS	

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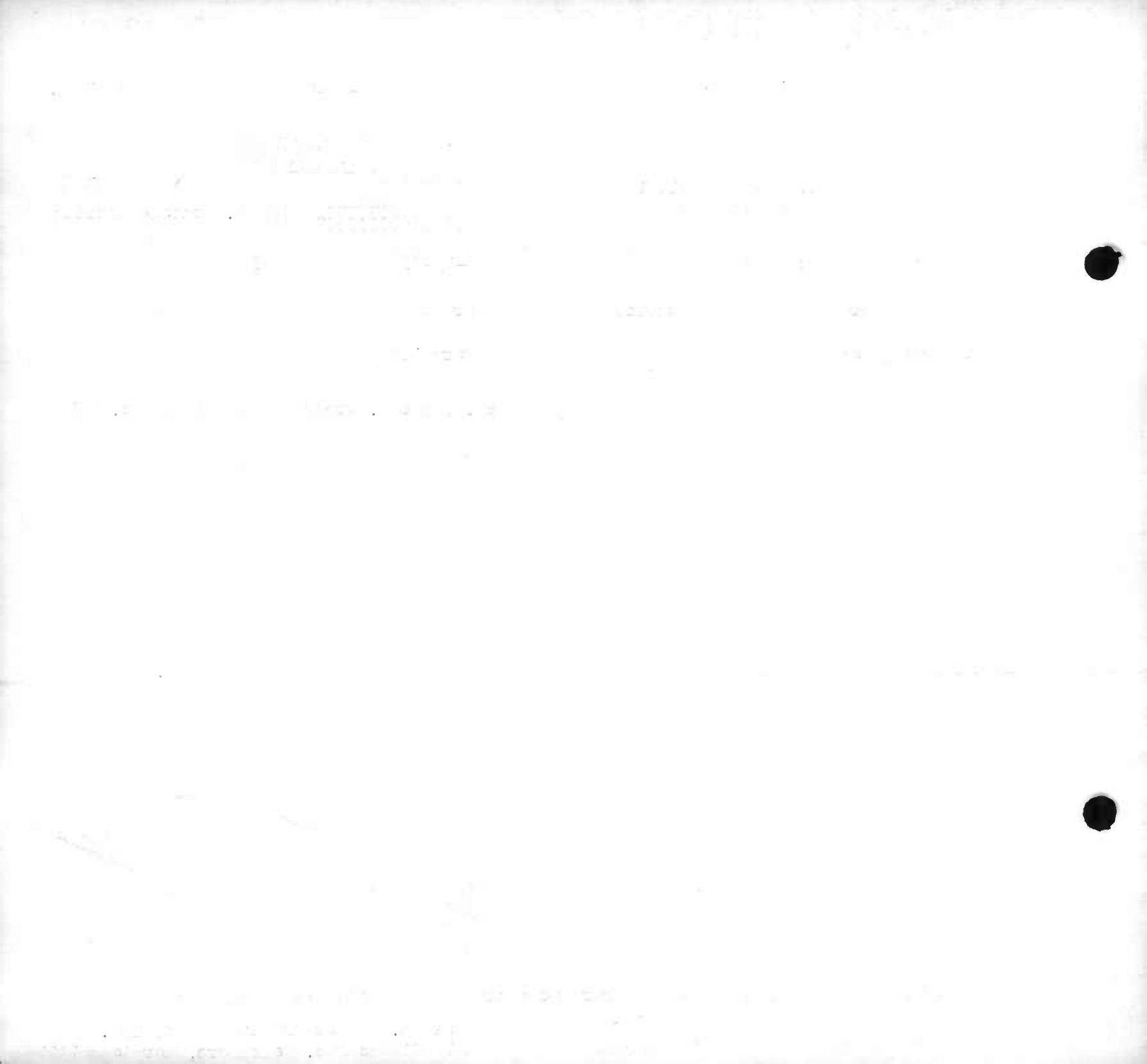
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>K-400</b>      <b>70 12864</b>      <b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p> <p style="text-align: right;">REG. NO. <b>70 12864</b></p>					
<p>BIRTH NO. _____</p>		<p>1. NAME OF DECEASED (Type or Print) <b>Sophia E. KAHL</b></p>		<p>2. DATE AND HOUR OF DEATH <b>12-31-70</b>      <b>8:55 P. M.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>St. Agnes Hospital Emergency Room</b></p>				<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b>      B. COUNTY <b>XXXXXXX</b></p> <p>C. CITY OR TOWN <b>BALTIMORE</b>      D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> <b>2005</b></p> <p>E. STREET AND NUMBER <b>XXXXXXX</b>      <b>355 S. Bentalou Street</b></p>	
<p>5. SEX <b>Female</b></p>	<p>6. RACE <b>Caucasian</b></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>2-19-86</b></p>		<p>9. AGE (In years last birthday) <b>85</b></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookbinder</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b></p>		<p>11. BIRTHPLACE (State or foreign country) <b>Maryland</b></p>	
<p>13. FATHER'S NAME <b>Augustus Kahl</b></p>				<p>14. MOTHER'S MAIDEN NAME <b>Mary Dietz</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT ADDRESS <b>Mrs. Marie R. Gross 4401 Roland Ave. 21210</b></p>	
<p>18. <b>4442 I</b> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Thrombosis of mesenteric</i></p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: _____</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: _____</p> <p>(C) _____</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). _____</p>					
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>1-1-70</b> to <b>12-31-70</b> that (I) (we) last saw the deceased alive on <b>12-8-70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <i>Vicente M. Ruano MD</i></p>				<p>23B. DATE SIGNED <b>1-1-71</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <i>Vicente M. Ruano MD</i></p>				<p>23D. ADDRESS <i>Spring Grove State Hospital</i></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>1/4/71</b></p>		<p>24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b></p>	
<p>24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b></p>		<p>24E. LOCATION (State) _____</p>		<p>24F. LOCATION (Country) _____</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>JAN 6 1971</b></p>		<p>25B. NAME OF REGISTRAR <i>Robert E. Taylor, Jr.</i></p>		<p>25C. FUNERAL DIRECTOR <b>Howard H. Hubbard Funeral Home, INC.</b></p>	
<p>25D. ADDRESS <b>4107 Wilkens Ave. Baltimore, Maryland 21229</b></p>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO.	
B-520		70 12865		70 12865	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>Earl Banks</b>			2. DATE AND HOUR OF DEATH <b>December 29, 1970 10:30 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4220 Euclid Ave.</b>			C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>Male</b> 6. RACE <b>White</b>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <b>5-7-1895</b>			9. AGE (In years last birthday) <b>75</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child Rehabilitation Center U.S. Gov.</b>			11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Thomas Banks</b>			14. MOTHER'S MAIDEN NAME <b>Julie Horton</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1917-1918</b>			16. SOCIAL SECURITY NO. <b>220-44-6195</b>		
17. INFORMANT <b>Grace A. Banks</b>			ADDRESS <b>4220 Euclid Ave.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>412.1</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CARDIAC ARREST</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 YEARS</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ISCHEMIC HEART DISEASE</b> <b>CORONARY ATHEROSCLEROSIS</b> <b>HYPERTENSION</b>		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>NONE</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <b>4-11-</b> 19 <b>68</b> to <b>12-29</b> 19 <b>70</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>12-29</b> 19 <b>70</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>Leah Coleman</i> M.D.				23B. DATE SIGNED <b>12-31-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>Leah Coleman</b>				23D. ADDRESS <b>5907 GWYNN OAK AVE BALTO, MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-2-71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mount View Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Carroll County Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 6 1971</b>			
25B. NAME OF REGISTRAR <b>Robert E. Galt</b>		25C. FUNERAL DIRECTOR <b>G. Truman Schwab</b>			
ADDRESS <b>5151 Balto. Nat. Pike</b>					



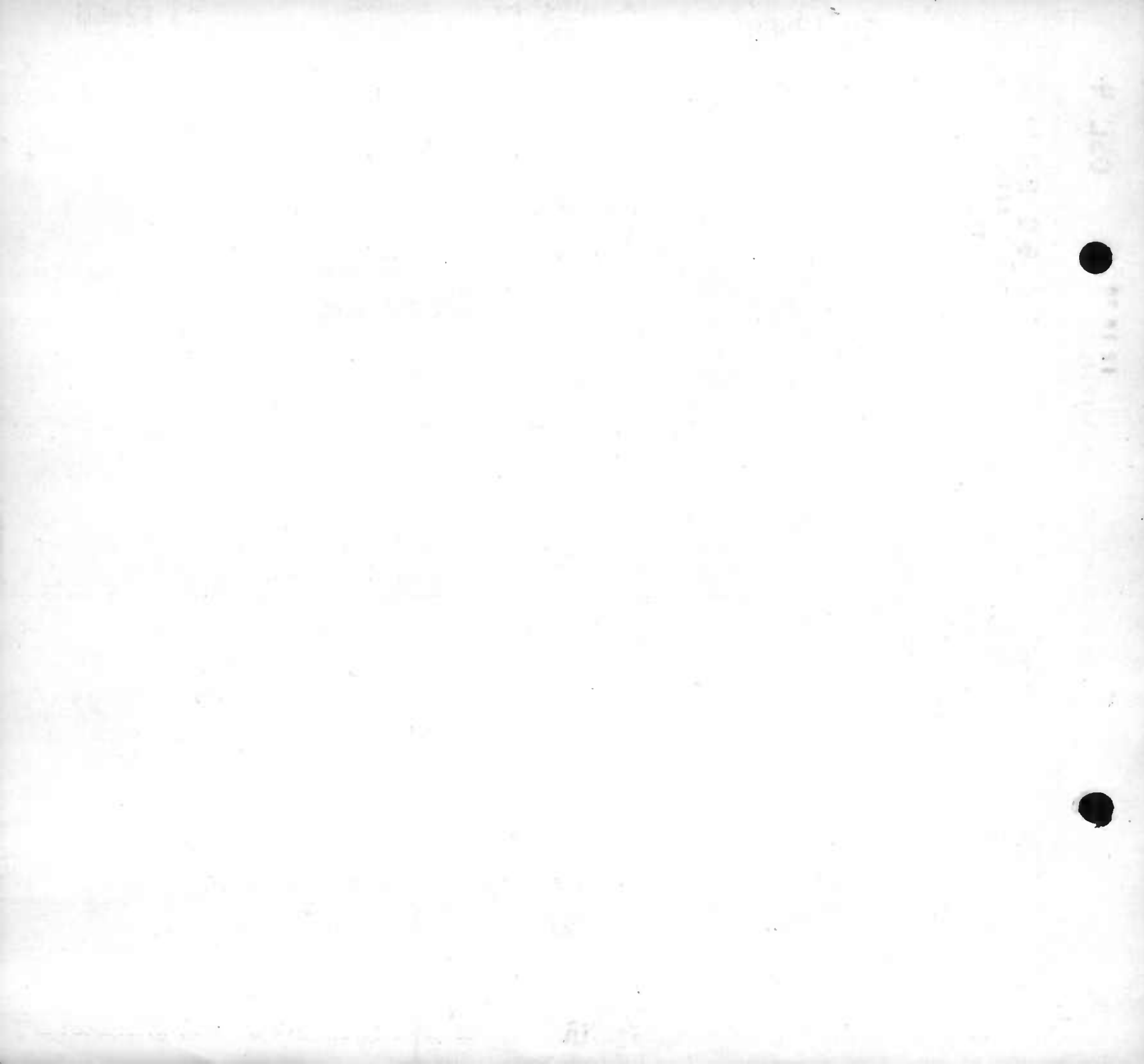
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12866	
70 12866				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Terry, Smith		2. DATE AND HOUR OF DEATH December 18, 1970 2:10 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY		C. CITY OR TOWN	
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 9/5/35	
13. FATHER'S NAME Albert Terry		14. MOTHER'S MAIDEN NAME Anna Chavis?		9. AGE (In years lost birthday) 35	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) Virginia	
17. INFORMANT Father		ADDRESS		12. CITIZEN OF WHAT COUNTRY?	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH I 7/10/71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiorespiratory Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7	
(B) DUE TO, OR AS A CONSEQUENCE OF: Brain Damage		(C) DUE TO, OR AS A CONSEQUENCE OF: Emboli from probable myocardial infarction		?	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from November 2 19 70 to December 18 19 70, that (H) (we) last saw the deceased alive on December 18 19 70 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert A. Adler, M.D.		23B. DATE SIGNED 12/18/70		23C. PHYSICIAN'S NAME (Type) Robert A. Adler, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-22-70		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cem	
25A. DATE REC'D BY HEALTH DEPT. JAN 6 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Rayner Sanders	
24D. LOCATION (City, town, or county) Md		24E. ADDRESS Johns Hopkins Hospital		24F. ADDRESS 217 E. Preston St	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12867</u>	
70 12867				CERTIFICATE OF DEATH	
BIRTH NO. <u>70 12867</u>		1. NAME OF DECEASED (Type or Print) <u>Clementine Caldwell</u>		2. DATE AND HOUR OF DEATH <u>Dec. 30, 1970</u> <u>8:45 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>Mercy Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md</u> B. COUNTY _____ C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>725 E. Preston St</u> <u>1001</u>		
5. SEX <u>F</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-12-18</u>	9. AGE (In years last birthday) <u>52</u>	10. Under 1 Yr. Months: _____ Days: _____ 11. Under 24 Hrs. Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Martha Marshall</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Record</u> ADDRESS _____	
18. <u>250.91</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>Cerebral Vascular accident</u> <u>Diabetes Mellitus</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/30</u> 19 <u>70</u> to <u>12/30</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>12/30</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Boo Keun Kiny</u> DEGREE _____				23B. DATE SIGNED <u>12/30/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Boo Keun Kiny</u> DEGREE _____				23D. ADDRESS <u>Mercy Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-5-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cem</u>	
24D. LOCATION (City, town, or county) <u>A.A.Co</u>		24E. (State) <u>Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 6 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Rayner Sanders</u> ADDRESS <u>217 E. Preston St</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

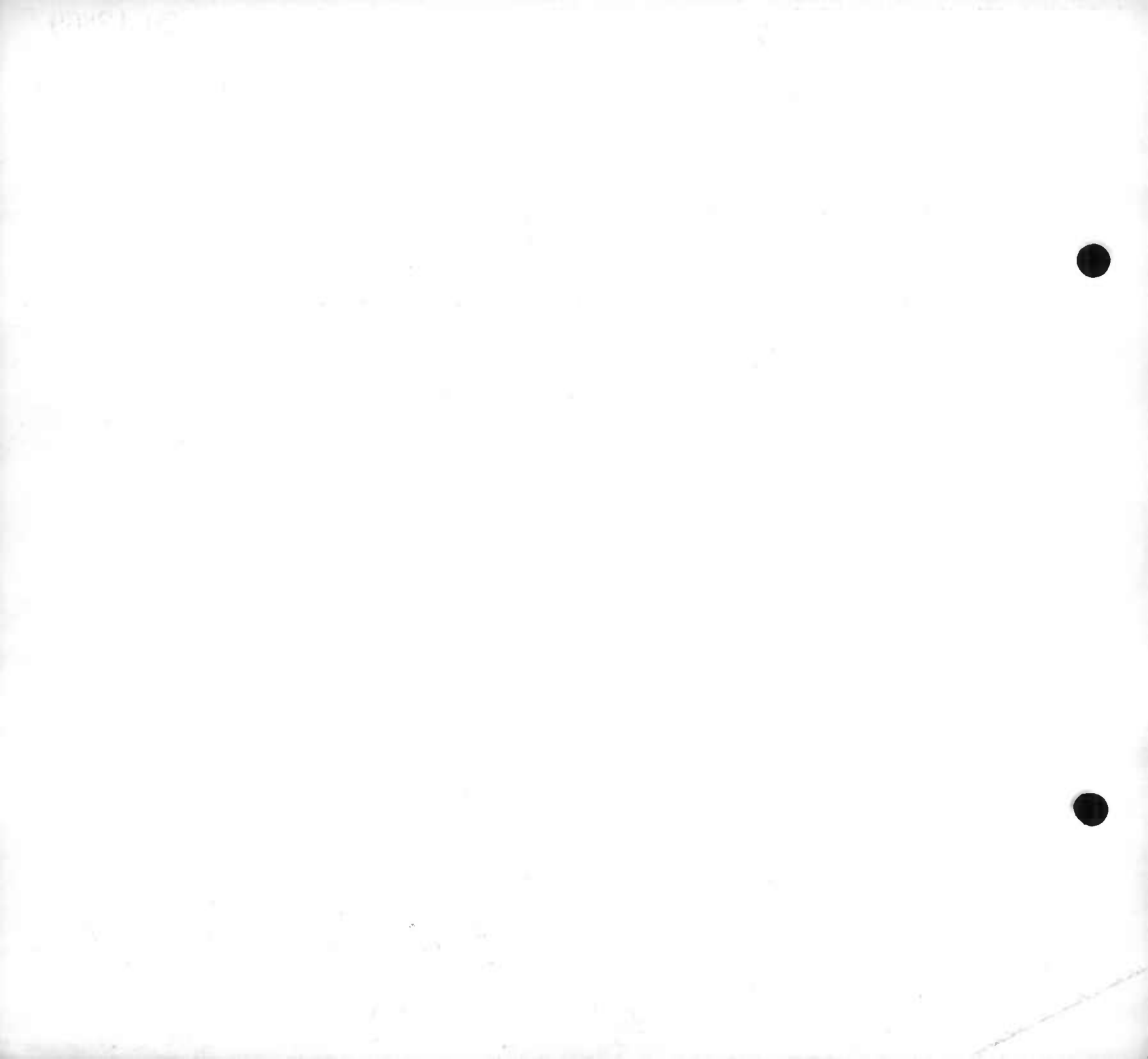
G-635 70 12868		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12868		4	
BIRTH NO. 70-21909				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Baby Girl "A" Gardner				2. DATE AND HOUR OF DEATH December 13, 1970 9:10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 12/13/70		9. AGE (In years last birthday) 16 min	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Thomas Mitchell Gardner				14. MOTHER'S MAIDEN NAME Virginia Elizabeth Simpkins			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mother	
18. 768.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Immaturity		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) 1st born of triplet			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/13 1970 to 12/13 1970 that (I) (we) last saw the deceased alive on 12/13 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Sang Y. Rhim, M.D.				23B. DATE SIGNED 12/13/70		23C. PHYSICIAN'S NAME (Type) SANG Y. RHIM	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE 12-21-70		24C. NAME OF CEMETERY OR CREMATION	
25A. DATE REC'D BY HEALTH DEPT. JAN 6 1971				25B. NAME OF REGISTRAR Robert E. J. Kelly, M.D.		25C. NAME OF FUNERAL DIRECTOR	
ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD							



**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 12869</u>	
BIRTH NO. <u>G-635</u> <u>70 12869</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Baby Girl "B" Gardner</u>		2. DATE AND HOUR OF DEATH <u>December 13 1970</u> <u>9:10A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South Baltimore General Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1516 Light St.</u> <u>2302</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/13/70</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE (In years last birthday) <u>10 mo</u> 11 Under 1 Yr. Months Days Hours Min. <u>0</u> <u>0</u> <u>0</u> <u>10</u>
13. FATHER'S NAME <u>Thomas Mitchell Gardner</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Elizabeth Simpkins</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mother</u> ADDRESS <u>1516 Light St.</u>	
18. <u>769.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Immaturity, Girl</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>2nd born of triplet</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Immaturity</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>2nd born of triplet</u> (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
19A. DATE OF OPERATION <u>12-21-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>No</u>	
20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>South Baltimore General Hospital</u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>12/13 1970 to 12/13 1970</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>12/13 1970</u> to <u>12/13 1970</u> and that (I) (we) last saw the deceased alive on <u>12/13 1970</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Song Y. Rhim, MD</u>		23B. DATE SIGNED <u>12/13/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Song Y. Rhim</u>		23D. ADDRESS <u>South Baltimore General Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>12-21-70</u>		24B. DATE <u>12-21-70</u>	
24C. NAME OF CEMETERY or CREMATORIUM <u>UNIVERSITY MEDICAL SCHOOL</u>		24D. LOCATION <u>MORTUARY SERVICE - BCTD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 6 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Gardner, R.A.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12870	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Stewart, baby boy		10/11/70			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Sinai Hospital Inc.			Md.		
			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
			Balto. 2802		
			E. STREET AND NUMBER		
			4204 Madison Ave. Belvedere Ave. of Green Spring		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
M	C		10/11/70		3 45
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Balto - Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
UNKNOWN			Alfreda Stewart		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Sinai Hospital.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
I This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Prematurity.		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Extreme Immaturity.		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 10/11/70 9:30 AM to 10/11/70 2:45 PM and that (I) (we) last saw the deceased alive on 10/11/70 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
[Signature] M.D.			10/11/70		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Carlos R. PEREL M.D.			Sinai Hospital - Balto - Md.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATOR	
		1-4-71		ANATOMY BOARD OF MARYLAND (Stated)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	
JAN 6 1971		Robert E. [Signature]			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

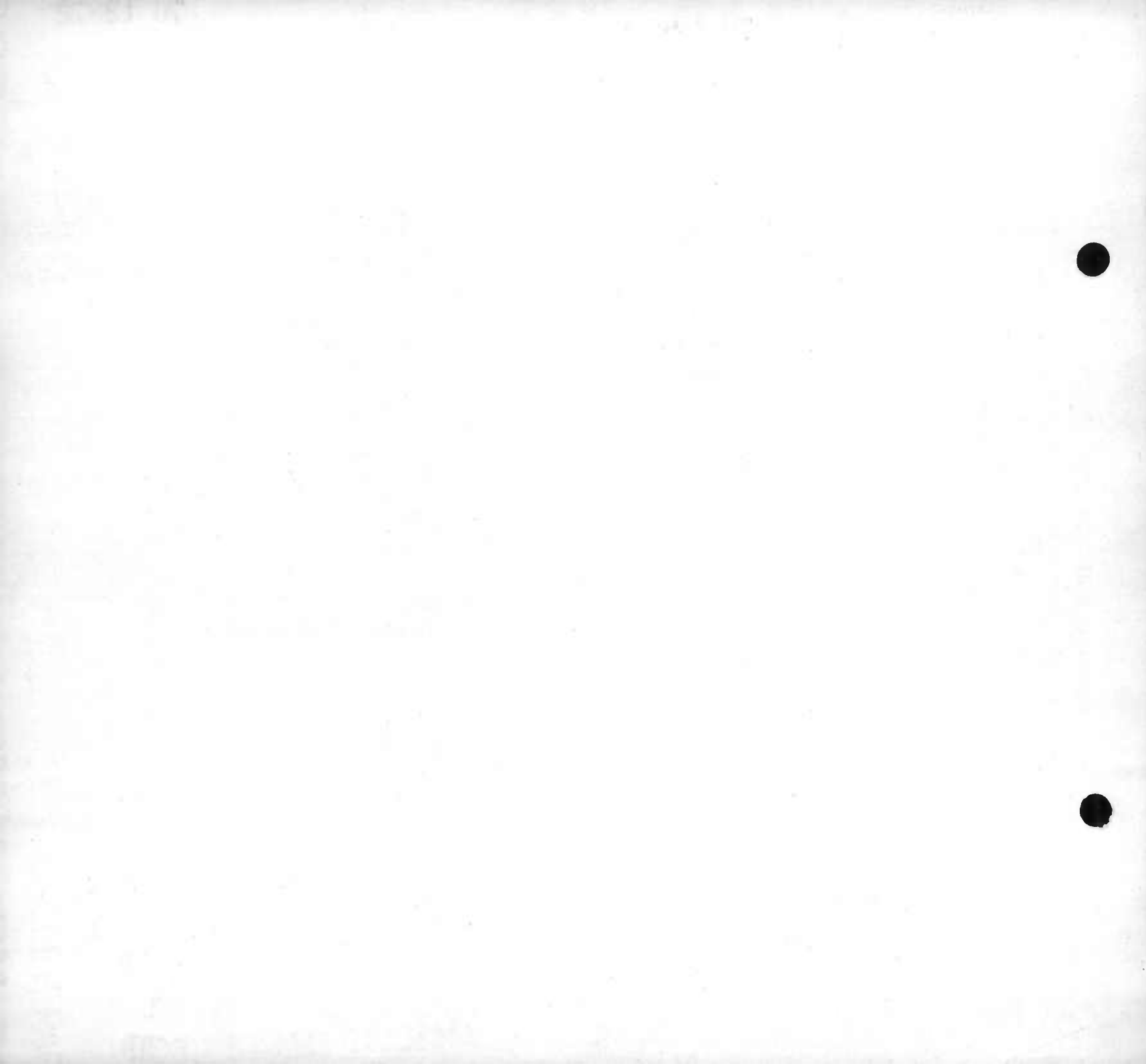
BALTIMORE CITY HEALTH DEPARTMENT				70 12871	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO. <u>70 235 38</u>		1. NAME OF DECEASED (Type or Print) <u>Baby girl Davis</u>		2. DATE AND HOUR OF DEATH <u>1.10 P.M. 9-26-70</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md.</u> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>5317 WABASH AVE. 284</u>					
5. SEX <u>Female</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/26/70</u>	9. AGE (in years last birthday)	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <u>5</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>John Davis</u>		14. MOTHER'S MAIDEN NAME <u>Theresa</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>72619 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>apnea</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Prematurity</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from <u>9-26-70</u> to <u>9-26-70</u> that (1) (we) last saw the deceased alive on <u>9-26-70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>N. Radfar, M.D.</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>NEZAM. RADFAR</u>	
23D. ADDRESS <u>Sinai Hosp.</u>		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>1-4-71</u>	
24C. NAME OF CEMETERY OR REPOSITORY		24D. NAME OF REGISTRAR		24E. DATE REC'D BY HEALTH DEPT.	
24F. NAME OF REGISTRAR		24G. NAME OF REGISTRAR		24H. NAME OF REGISTRAR	
24I. NAME OF REGISTRAR		24J. NAME OF REGISTRAR		24K. NAME OF REGISTRAR	
24L. NAME OF REGISTRAR		24M. NAME OF REGISTRAR		24N. NAME OF REGISTRAR	
24O. NAME OF REGISTRAR		24P. NAME OF REGISTRAR		24Q. NAME OF REGISTRAR	
24R. NAME OF REGISTRAR		24S. NAME OF REGISTRAR		24T. NAME OF REGISTRAR	
24U. NAME OF REGISTRAR		24V. NAME OF REGISTRAR		24W. NAME OF REGISTRAR	
24X. NAME OF REGISTRAR		24Y. NAME OF REGISTRAR		24Z. NAME OF REGISTRAR	
24AA. NAME OF REGISTRAR		24AB. NAME OF REGISTRAR		24AC. NAME OF REGISTRAR	
24AD. NAME OF REGISTRAR		24AE. NAME OF REGISTRAR		24AF. NAME OF REGISTRAR	
24AG. NAME OF REGISTRAR		24AH. NAME OF REGISTRAR		24AI. NAME OF REGISTRAR	
24AJ. NAME OF REGISTRAR		24AK. NAME OF REGISTRAR		24AL. NAME OF REGISTRAR	
24AM. NAME OF REGISTRAR		24AN. NAME OF REGISTRAR		24AO. NAME OF REGISTRAR	
24AP. NAME OF REGISTRAR		24AQ. NAME OF REGISTRAR		24AR. NAME OF REGISTRAR	
24AS. NAME OF REGISTRAR		24AT. NAME OF REGISTRAR		24AU. NAME OF REGISTRAR	
24AV. NAME OF REGISTRAR		24AW. NAME OF REGISTRAR		24AX. NAME OF REGISTRAR	
24AY. NAME OF REGISTRAR		24AZ. NAME OF REGISTRAR		24BA. NAME OF REGISTRAR	
24BB. NAME OF REGISTRAR		24BC. NAME OF REGISTRAR		24BD. NAME OF REGISTRAR	
24BE. NAME OF REGISTRAR		24BF. NAME OF REGISTRAR		24BG. NAME OF REGISTRAR	
24BH. NAME OF REGISTRAR		24BI. NAME OF REGISTRAR		24BJ. NAME OF REGISTRAR	
24BK. NAME OF REGISTRAR		24BL. NAME OF REGISTRAR		24BM. NAME OF REGISTRAR	
24BN. NAME OF REGISTRAR		24BO. NAME OF REGISTRAR		24BP. NAME OF REGISTRAR	
24BQ. NAME OF REGISTRAR		24BR. NAME OF REGISTRAR		24BS. NAME OF REGISTRAR	
24BT. NAME OF REGISTRAR		24BU. NAME OF REGISTRAR		24BV. NAME OF REGISTRAR	
24BW. NAME OF REGISTRAR		24BX. NAME OF REGISTRAR		24BY. NAME OF REGISTRAR	
24BZ. NAME OF REGISTRAR		24CA. NAME OF REGISTRAR		24CB. NAME OF REGISTRAR	
24CC. NAME OF REGISTRAR		24CD. NAME OF REGISTRAR		24CE. NAME OF REGISTRAR	
24CD. NAME OF REGISTRAR		24CE. NAME OF REGISTRAR		24CF. NAME OF REGISTRAR	
24CE. NAME OF REGISTRAR		24CF. NAME OF REGISTRAR		24CG. NAME OF REGISTRAR	
24CF. NAME OF REGISTRAR		24CG. NAME OF REGISTRAR		24CH. NAME OF REGISTRAR	
24CG. NAME OF REGISTRAR		24CH. NAME OF REGISTRAR		24CI. NAME OF REGISTRAR	
24CH. NAME OF REGISTRAR		24CI. NAME OF REGISTRAR		24CJ. NAME OF REGISTRAR	
24CI. NAME OF REGISTRAR		24CJ. NAME OF REGISTRAR		24CK. NAME OF REGISTRAR	
24CJ. NAME OF REGISTRAR		24CK. NAME OF REGISTRAR		24CL. NAME OF REGISTRAR	
24CK. NAME OF REGISTRAR		24CL. NAME OF REGISTRAR		24CM. NAME OF REGISTRAR	
24CL. NAME OF REGISTRAR		24CM. NAME OF REGISTRAR		24CN. NAME OF REGISTRAR	
24CM. NAME OF REGISTRAR		24CN. NAME OF REGISTRAR		24CO. NAME OF REGISTRAR	
24CN. NAME OF REGISTRAR		24CO. NAME OF REGISTRAR		24CP. NAME OF REGISTRAR	
24CO. NAME OF REGISTRAR		24CP. NAME OF REGISTRAR		24CQ. NAME OF REGISTRAR	
24CP. NAME OF REGISTRAR		24CQ. NAME OF REGISTRAR		24CR. NAME OF REGISTRAR	
24CQ. NAME OF REGISTRAR		24CR. NAME OF REGISTRAR		24CS. NAME OF REGISTRAR	
24CR. NAME OF REGISTRAR		24CS. NAME OF REGISTRAR		24CT. NAME OF REGISTRAR	
24CS. NAME OF REGISTRAR		24CT. NAME OF REGISTRAR		24CU. NAME OF REGISTRAR	
24CT. NAME OF REGISTRAR		24CU. NAME OF REGISTRAR		24CV. NAME OF REGISTRAR	
24CU. NAME OF REGISTRAR		24CV. NAME OF REGISTRAR		24CW. NAME OF REGISTRAR	
24CV. NAME OF REGISTRAR		24CW. NAME OF REGISTRAR		24CX. NAME OF REGISTRAR	
24CW. NAME OF REGISTRAR		24CX. NAME OF REGISTRAR		24CY. NAME OF REGISTRAR	
24CX. NAME OF REGISTRAR		24CY. NAME OF REGISTRAR		24CZ. NAME OF REGISTRAR	
24CY. NAME OF REGISTRAR		24CZ. NAME OF REGISTRAR		24DA. NAME OF REGISTRAR	
24CZ. NAME OF REGISTRAR		24DA. NAME OF REGISTRAR		24DB. NAME OF REGISTRAR	
24DA. NAME OF REGISTRAR		24DB. NAME OF REGISTRAR		24DC. NAME OF REGISTRAR	
24DB. NAME OF REGISTRAR		24DC. NAME OF REGISTRAR		24DD. NAME OF REGISTRAR	
24DC. NAME OF REGISTRAR		24DD. NAME OF REGISTRAR		24DE. NAME OF REGISTRAR	
24DD. NAME OF REGISTRAR		24DE. NAME OF REGISTRAR		24DF. NAME OF REGISTRAR	
24DE. NAME OF REGISTRAR		24DF. NAME OF REGISTRAR		24DG. NAME OF REGISTRAR	
24DF. NAME OF REGISTRAR		24DG. NAME OF REGISTRAR		24DH. NAME OF REGISTRAR	
24DG. NAME OF REGISTRAR		24DH. NAME OF REGISTRAR		24DI. NAME OF REGISTRAR	
24DH. NAME OF REGISTRAR		24DI. NAME OF REGISTRAR		24DJ. NAME OF REGISTRAR	
24DI. NAME OF REGISTRAR		24DJ. NAME OF REGISTRAR		24DK. NAME OF REGISTRAR	
24DJ. NAME OF REGISTRAR		24DK. NAME OF REGISTRAR		24DL. NAME OF REGISTRAR	
24DK. NAME OF REGISTRAR		24DL. NAME OF REGISTRAR		24DM. NAME OF REGISTRAR	
24DL. NAME OF REGISTRAR		24DM. NAME OF REGISTRAR		24DN. NAME OF REGISTRAR	
24DM. NAME OF REGISTRAR		24DN. NAME OF REGISTRAR		24DO. NAME OF REGISTRAR	
24DN. NAME OF REGISTRAR		24DO. NAME OF REGISTRAR		24DP. NAME OF REGISTRAR	
24DO. NAME OF REGISTRAR		24DP. NAME OF REGISTRAR		24DQ. NAME OF REGISTRAR	
24DP. NAME OF REGISTRAR		24DQ. NAME OF REGISTRAR		24DR. NAME OF REGISTRAR	
24DQ. NAME OF REGISTRAR		24DR. NAME OF REGISTRAR		24DS. NAME OF REGISTRAR	
24DR. NAME OF REGISTRAR		24DS. NAME OF REGISTRAR		24DT. NAME OF REGISTRAR	
24DS. NAME OF REGISTRAR		24DT. NAME OF REGISTRAR		24DU. NAME OF REGISTRAR	
24DT. NAME OF REGISTRAR		24DU. NAME OF REGISTRAR		24DV. NAME OF REGISTRAR	
24DU. NAME OF REGISTRAR		24DV. NAME OF REGISTRAR		24DV. NAME OF REGISTRAR	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.
P-412 70-21643 70 12872		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>PHILLIPS, BABY BOY</b>		2. DATE AND HOUR OF DEATH <b>11-13-70 12:31 A M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL OF BALTO. INC.</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4320 REISTERSTOWN RD. 1513</b>		
5. SEX <b>M</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/12/70</b>	9. AGE (In years lost birthday) <b>47</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>DONALD FORD</b>		
14. MOTHER'S MAIDEN NAME <b>PHILLIPS, Betty</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>759.91</b> <b>PREMATURITY 30wks gestation</b> <b>MULTIPLE LONGITUDINAL ANOMALIES</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Premature Rupture of Membranes</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>11-12-70</b> to <b>11-13-70</b> and that (I) (we) last saw the deceased alive on <b>11-13-70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Glinda P. Tugade, M.D.</b>		23B. DATE SIGNED <b>11-13-70</b>		23C. PHYSICIAN'S NAME (Type) <b>GLINDA P. TUGADE, M.D.</b>
23D. ADDRESS <b>Sinai Hospital of Balto, Inc.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>1-4-71</b>		
24B. DATE <b>1-4-71</b>		24C. NAME OF CEMETERY <b>ANATOMY BOARD OF MARYLAND</b>		
24D. DATE REC'D. BY HEALTH DEPT. <b>JAN 6 1971</b>		24E. NAME OF REGISTRAR <b>UNIVERSITY MEDICAL SCHOOL</b>		
24F. NAME OF FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHO</b>		24G. ADDRESS		



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <u>70 12873</u>	
BIRTH NO. <u>70-12626</u>		2. DATE AND HOUR OF DEATH <u>7/28/70</u> <u>1312</u> A.M.	
1. NAME OF DECEASED (Type or Print) <u>Baby Girl Johnson</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Sinai Hosp of Balto</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hosp of Balto</u>		E. STREET AND NUMBER <u>6610 VINCENT LANE 2831</u>	
5. SEX <u>F</u>	6. RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/14/70</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NA</u>	10B. KIND OF BUSINESS OR INDUSTRY <u>NA</u>	9. AGE (In years last birthday) <u>14</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore MD</u>
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
14. MOTHER'S MAIDEN NAME <u>Denise Johnson</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>NA</u>		17. INFORMANT ADDRESS	
18. <u>726.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
(A) IMMEDIATE CAUSE <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Prematurity (820 gm)</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>7/15/70</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/15/70</u> 19 <u>70</u> to <u>7/28/70</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>7/28/70</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Victoria Schauf, M.D.</u>		23B. DATE SIGNED <u>7/28/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Victoria Schauf, M.D.</u>		23D. ADDRESS <u>Sinai</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>1-4-71</u>	24B. DATE	24C. NAME OF CEMETERY	24D. LOCATION (City, town, or county) (State)
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>	25C. FUNERAL DIRECTOR ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

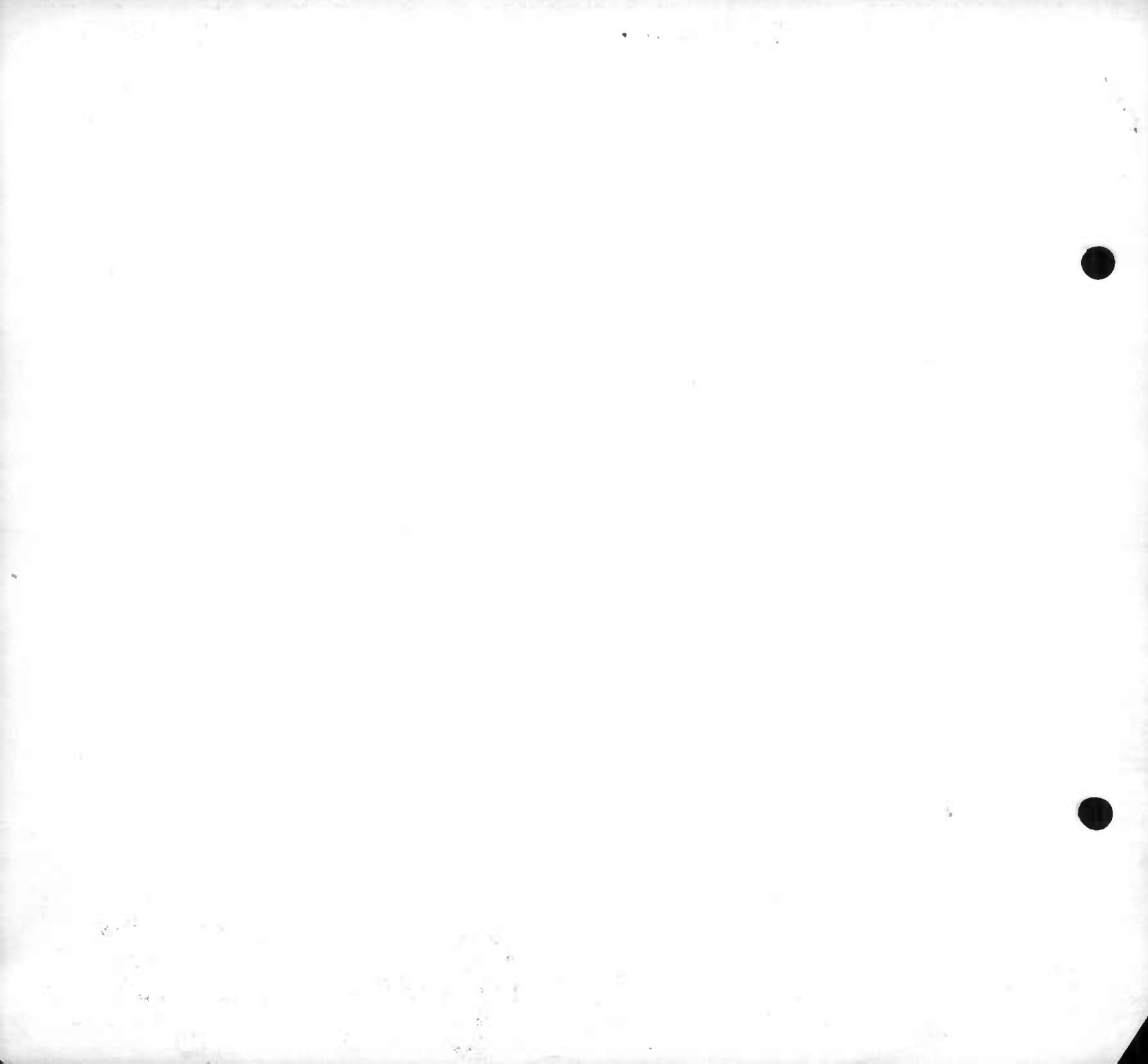
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>495-159</u>	
C-600		BIRTH NO. <u>70-2060870 12874</u>	
1. NAME OF DECEASED (Type or Print) <u>BABY GIRL CARR</u>		2. DATE AND HOUR OF DEATH <u>11-19-70</u> <u>4:00 A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 SINAI HOSP. BALTO</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE _____ B. COUNTY _____	
		C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>17 N. RAYSON STREET</u>	
5. SEX <u>F</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11-18-70</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>6 mos.</u>
11. BIRTHPLACE (State or foreign country) <u>Sinai Hosp.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE CARR</u>		14. MOTHER'S MAIDEN NAME <u>LUCY</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
18. <u>726.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardio res. arrest</u> <u>Hyaline membrane disease / prematurity</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hyaline membrane disease / prematurity</u>	
		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>ly</u>	
		(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>2</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>YES</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11-18-70</u> 19 to <u>11-19-70</u> 19 that (I) (we) last saw the deceased alive on <u>11-19-70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Glinnda P. Tugade</u>		23B. DATE SIGNED <u>11-19-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>GLINDA P. TUGADE</u>		23D. ADDRESS <u>Sinai Hosp.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>1-4-71</u>	24B. DATE	24C. NAME OF CEMETERY or CREMATOR <u>ANATOMY BOARD OF MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 6 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Tugade</u>	
UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCD			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

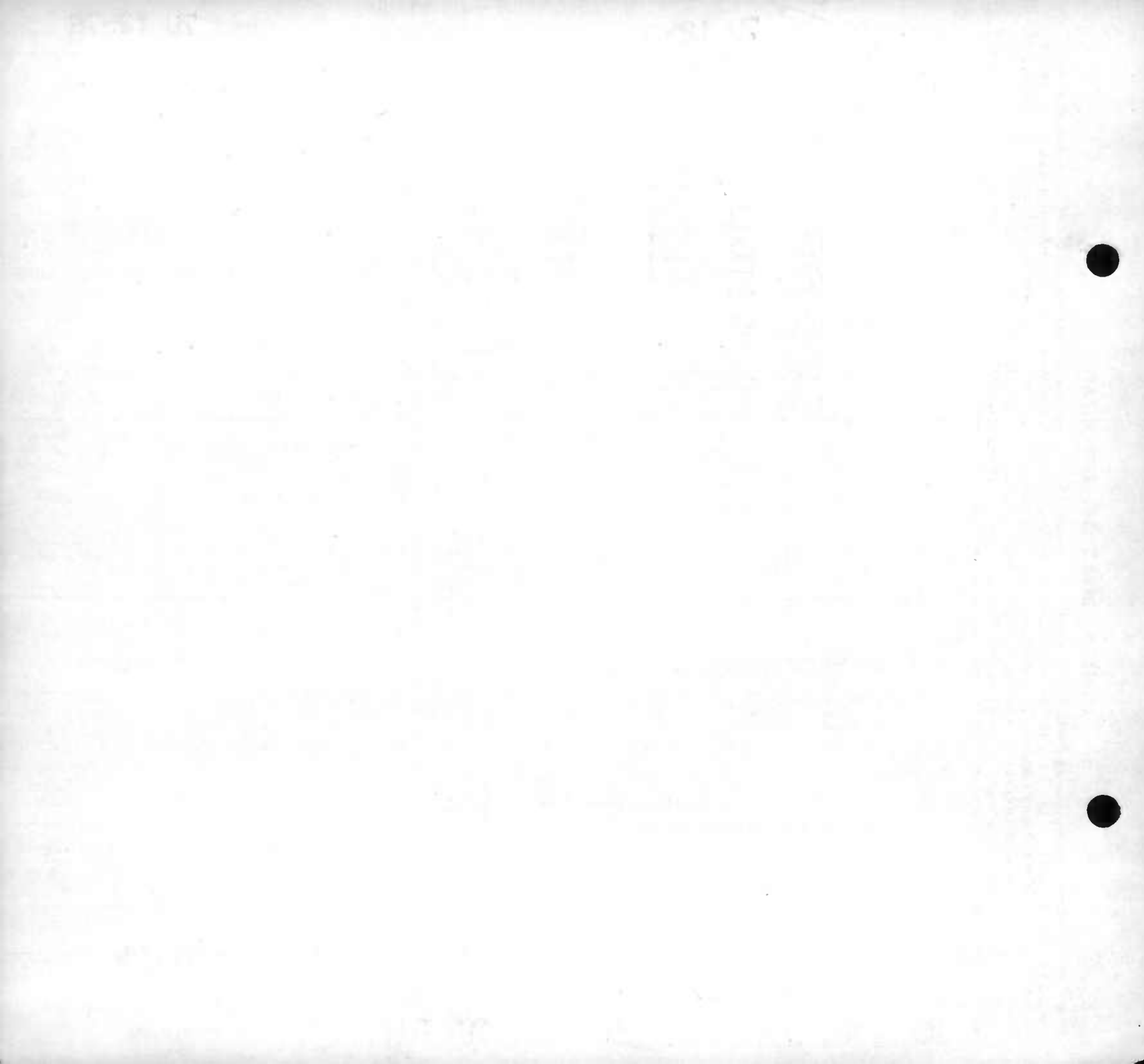
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12875	
BIRTH NO. 70 12875		70 12875			
1. NAME OF DECEASED (Type or Print) FLORENCE BOWMAN		2. DATE AND HOUR OF DEATH 12/22/70 9:15A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH AVE AND HOSP		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1605 E. BALTIMORE 351			
5. SEX F	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/16/18	9. AGE (in years last birthday) 52	10. Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT nat's Hosp. CRAT No 437322731	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E 930.13 Acute Respiratory Failure Antecedent Causes Diseases or Conditions, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Respiratory Failure (B) DUE TO, OR AS A CONSEQUENCE OF: Pneumothorax & Valvular Overdose (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1605 E Baltimore St 3-01	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx) 12-19-70		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Suicide - O.D.	
22. I certify that (I) (this hospital) attended the deceased from 12/19/70 to 12/22/70 that (I) (we) last saw the deceased alive on 12/22/70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B. C. Veneracion J. Mendez		23B. DATE SIGNED 12/22/70		23C. PHYSICIAN'S NAME (Type) B. C. VENERACION J. MEND. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) 1-5-71		24B. DATE 1-5-71		24C. NAME OF CEMETERY OR CREMATOR ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JAN 6 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Sec.		25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>70 12876</b>	
<b>7-655-1795970 12876</b> BIRTH NO. <b>70-1795970</b>		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>Baby Thurman</b>		2. DATE AND HOUR OF DEATH <b>2.40 AM 10/8/70</b>   <b>2.40 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 Sinai Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>21215</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3007 Rosalind Ave</b>	
5. SEX <b>male</b>	6. RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/7/70</b>
9. AGE (In years, lost birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10. B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>James C Chase</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Thurman</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>mother</b> ADDRESS <b>3007 Rosalind Ave. 21215</b>
18. <b>486X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Aspiration Pneumonia</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>10/8/70</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>10/7/70</b> 19 <b>70</b> to <b>10/8</b> 19 <b>70</b> , that (1) (we) last saw the deceased alive on <b>10/8/70</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>N. Radfar, M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <b>10/8/70</b>
23C. PHYSICIAN'S NAME (Type) <b>NEZAM RADFAR</b>		23D. ADDRESS <b>SINAI HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>1-4-71</b>	24B. DATE	24C. NAME OF CEMETERY OR PLACE OF BURIAL <b>ANATOMY BOARD OF MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 8 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR		25D. ADDRESS	
<b>UNIVERSITY MEDICAL SCHOOL</b> <b>MORTUARY SERVICE - BOLD</b>			



# FUNERAL DIRECTOR: IMPORTANT

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B-620 70 12877		BALTIMORE CITY HEALTH DEPARTMENT		70 12877	
BIRTH NO.		1. NAME OF DECEASED Type or Print <b>BROOKS MARIE</b>		2. DATE AND HOUR OF DEATH <b>12/30/70</b> <b>3 20</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b> CITY		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIV. OF MARYLAND</b>		E. STREET AND NUMBER <b>22 S. GREENE ST</b>		F. STREET AND NUMBER <b>222 CRESSWELL</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/13/18</b>	9. AGE (In years last birthday) <b>52</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Edward Simmons</b>		14. MOTHER'S MAIDEN NAME <b>CHART</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>CHART</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>HEART FAILURE</b>		CAUSE OF DEATH <b>HEART FAILURE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>40 MIN</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>HEART FAILURE</b>		<b>1 WEEK</b>	
		(B) <b>HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>HEART FAILURE</b>		<b>1 WEEK</b>	
		(C) <b>HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>HEART FAILURE</b>		<b>1 WEEK</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>NONE</b>					
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>		20A. AUTOPSY (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NONE</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NONE</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>NONE</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <b>NONE</b>		21F. HOW DID INJURY OCCUR? <b>NONE</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>12/29/70</b> 19 <b>70</b> to <b>12/30</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>12/30</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>James Allan</b>		23B. DATE SIGNED <b>12/30/70</b>		23C. PHYSICIAN'S NAME (Type) <b>JAMES ALLAN MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/4/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Crest Lawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Howard Co., Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 6 1971</b>		25B. NAME OF REGISTRAR <b>George J. Gonca</b>	
25C. FUNERAL DIRECTOR <b>George J. Gonca</b>		25D. ADDRESS <b>4001 Ritchie Hgy. Baltimore, Md. 21225</b>		25E. ADDRESS <b>4001 Ritchie Hgy. Baltimore, Md. 21225</b>	



FUNERAL DIRECTOR: IMPORTANT

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70 12878		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 12878	
BIRTH NO.		1. NAME OF DECEASED (Type and Print) <i>Sheldon CRAIG HILLIARD</i>		2. DATE AND HOUR OF DEATH <i>12/28/70 5:00</i> <i>A.</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTO</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 SINAI HOSPITAL</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>1724 N. Bentall St</i>			
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2/2/61</i>	9. AGE (in years last birthday) <i>9</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Child</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>BALTO, MD</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>WILLIAM Z. Hilliard</i>		14. MOTHER'S MAIDEN NAME <i>JENNIE Bailey</i>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. William Hilliard</i> ADDRESS <i>1724 N. Bentall St</i>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE <i>Massive Pleural Effusion</i> DUE TO, OR AS A CONSEQUENCE OF:					
(B) <i>LYMPH SARCOMA</i> DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>12/28/70</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(it)</del> (this hospital) attended the deceased from <i>12/28</i> 19 <i>70</i> to <i>12/28</i> 19 <i>70</i> and that <del>he</del> (we) last saw the deceased alive on <i>12/28</i> 19 <i>70</i> and that <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Carmen E. Cemprom</i>				23B. DATE SIGNED <i>12/28/70</i>	
23C. PHYSICIAN'S NAME (Typical) <i>CARMEN E. CEMPRON, M.D.</i>				23D. ADDRESS <i>SINAI HOSP</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/31/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Orchard View Park</i>	
24D. LOCATION (City, town, or county) (State) <i>MD.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 7 1971</i>			
25B. NAME OF REGISTRAR <i>Robert E. Fisher, R.D.</i>		25C. FUNERAL DIRECTOR <i>Joseph R. Russ</i> ADDRESS <i>2222 N. Harford Ave</i>			



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70 12879

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12879

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>SAMUEL JEFFERSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>43 South Baltimore General Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 25 1970 12:45 a.m.</b>	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>Dec. 6</b>		10. AGE (in years lost birthday) <b>33</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Malachi Jefferson</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME <b>Frances Hair</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. <b>212-346318</b>		18. INFORMANT <b>Mrs. Louise Jefferson</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Epilepsy</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> DATE SIGNED <b>12-25-70</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/29/70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. B. M.D.</b>	
25C. FUNERAL DIRECTOR <b>Joseph E. King</b>		ADDRESS <b>512 N. Carrollton St</b>	

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## BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12880

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES HARRIS Jr.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> <b>December 30, 1970</b> 10:30 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>December 30, 1970</b> 10:30 P.M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Sept 11, 1910</b>		10. AGE (In years lost birthday) <b>60</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>216-01-1151</b>	
18. INFORMANT <b>Virginia Harris</b>		ADDRESS <b>902 Bridgeway Rd.</b>	
19. CAUSE OF DEATH <b>E880X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Epidural hematoma in upper thoracic spinal canal (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>506 N. Gilmore Street</b>		22D. TIME (Month) (Day) (Year) (Hour) <b>12-6-70 10:10 P.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Fell down stairs</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>December 31, 1970</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Jan. 4, 1971</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery Westport (Baltimore) Md.</b>		24D. LOCATION (City, town or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Joseph H. Kue</b>		ADDRESS <b>2222 W. North Ave</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 12881		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 12881	
1. NAME OF DECEASED (Type or Print) <u>KELLY VAUGHN</u>		2. DATE AND HOUR OF DEATH <u>Dec 26 1970</u> <u>11:30P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>4613 Park Heights Ave</u> <u>90 Mt. Sinai Nursing Home</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Maryland</u> B. COUNTY <u>1509</u>	
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>4009 Fairview Ave</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-4-97</u>	9. AGE (in years last birthday) <u>73</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>	
13. FATHER'S NAME <u>Glenn Vaughn</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Vaughn</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>U.S.N.</u>		16. SOCIAL SECURITY NO. <u>225-16-9359</u>		17. INFORMANT <u>Miss Dorothy Vaughn</u> ADDRESS <u>4009 Fairview Ave</u>	
18. <u>4367 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Chronic Renal Failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cerebral Vascular Accident 2 years</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic Renal Failure</u>		(B) <u>Cerebral Vascular Accident 2 years</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 27 1970</u> to <u>Dec 26 1970</u> and that (I) (we) lost saw the deceased alive on <u>Dec 25 1970</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <u>Louis T. Lavoy</u>		23B. DATE SIGNED <u>Dec 27 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>LOUIS T. LAVOY</u>	
		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23D. ADDRESS <u>3502 W. Rogers Ave Baltimore Md</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-30-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem</u>	
				24D. LOCATION (City, town, or county) (State) <u>Wootton Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 7 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Joseph H. Russ</u> ADDRESS <u>22224 North Ave</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

X-632		70 12882		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		70 12882	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CHARLOTTE KERTZER</b>				2. DATE AND HOUR OF DEATH <b>12/31/70 2:15 p.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		<b>MD</b>		<b>2788</b>			
<b>BINGH HOSPITAL OF BALTIMORE</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <b>5361 Cordelia Ave #15</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>XXXXXX/XX/XX</b>		9. AGE (In years last birthday) <b>42</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>LOUIS KERTZER</b>				14. MOTHER'S MAIDEN NAME <b>BERTHA LUTZ</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. BERTHA KERTZER, 5361 CORDELIA AVE. #15</b>		ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (All stating the UNDERLYING CONDITION last.) <b>CAUSE OF DEATH</b>		(B) <b>Leukemia chronic lymphocytic</b> DUE TO, OR AS A CONSEQUENCE OF:							
(C)									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<b>Brainic ileny</b>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <b>12/28/70</b> to <b>12/31/70</b> that (2) (we) last saw the deceased alive on <b>12/31/70</b> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>[Signature]</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/31/70</b>			
23C. PHYSICIAN'S NAME (Type) <b>RUC - AN 7726</b>		23D. ADDRESS <b>Bingh Hospital</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-3-71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>SWINICHER WOLINER BENEVOLENT SOCIETY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS.</b>		ADDRESS <b>6010 REISTERSTOWN ROAD</b>			



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70 12883

BALTIMORE CITY HEALTH DEPARTMENT

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 12883

REG. NO.

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
ROBERT L. JEWELL		Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> December 31, 1970 4:30 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		3. DATE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Month Day Year December 31, 1970 4:30 A. M.	
31 BALTIMORE CITY HOSPITAL		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
6. SEX Male		A. STATE Maryland	
7. RACE White		B. COUNTY Baltimore	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH October 3, 1953		10. AGE (In years last birthday) 17	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert L. Jewell		14. STREET AND NUMBER 921 Elton Avenue	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Doris G. Blokley		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 215-64-8723		18. INFORMANT Father: 921 Elton Avenue Mr. Robert L. Jewell Balto. Md. 21224	
19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Multiple injuries DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Northpoint Blvd. N. of Merritt Blvd.	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 12-30-70 8:30 P. M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Pedestrian struck by auto		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-4-71	
24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1971		25B. NAME OF REGISTRAR John J. Duda	
25C. FUNERAL DIRECTOR 7922 Wise Ave. Dundalk, Md.		25D. ADDRESS	

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BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 12884

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>DOMINIC J. PITTELLI</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>December 30, 1970</b>		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospital (DQA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>December 30, 1970</b>		Hour <b>4:06 P. M.</b>
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH <b>April 3, 1922</b>		10. AGE (In years lost birthday) <b>48</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF <b>U. S. A.</b>		13. FATHER'S NAME <b>Vincent Pittelli</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Worker Bethlehem Steel Co.</b>
15. MOTHER'S MAIDEN NAME <b>Catherine Averza</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		17. SOCIAL SECURITY NO. <b>215-12-4937</b>
18. INFORMANT (Wife) <b>Box 808</b>		ADDRESS Rt. #10 <b>Mrs. Opal M. Pittelli, Balto. Md. 21219</b>		19. CAUSE OF DEATH <b>Multiple injuries</b>
20A. DATE OF OPERATION <b>12-30-70</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Millers Island N. of 12th St. Balt.</b>
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>12-30-70 4:06 P. M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Driver in fixed object collision</b>
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b> DATE SIGNED <b>December 31, 1970</b> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/4/71</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1971</b>		
25B. NAME OF REGISTRAR <b>John J. Duda, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		

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COMMUNICATIONS SECTION

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TO DIRECTOR

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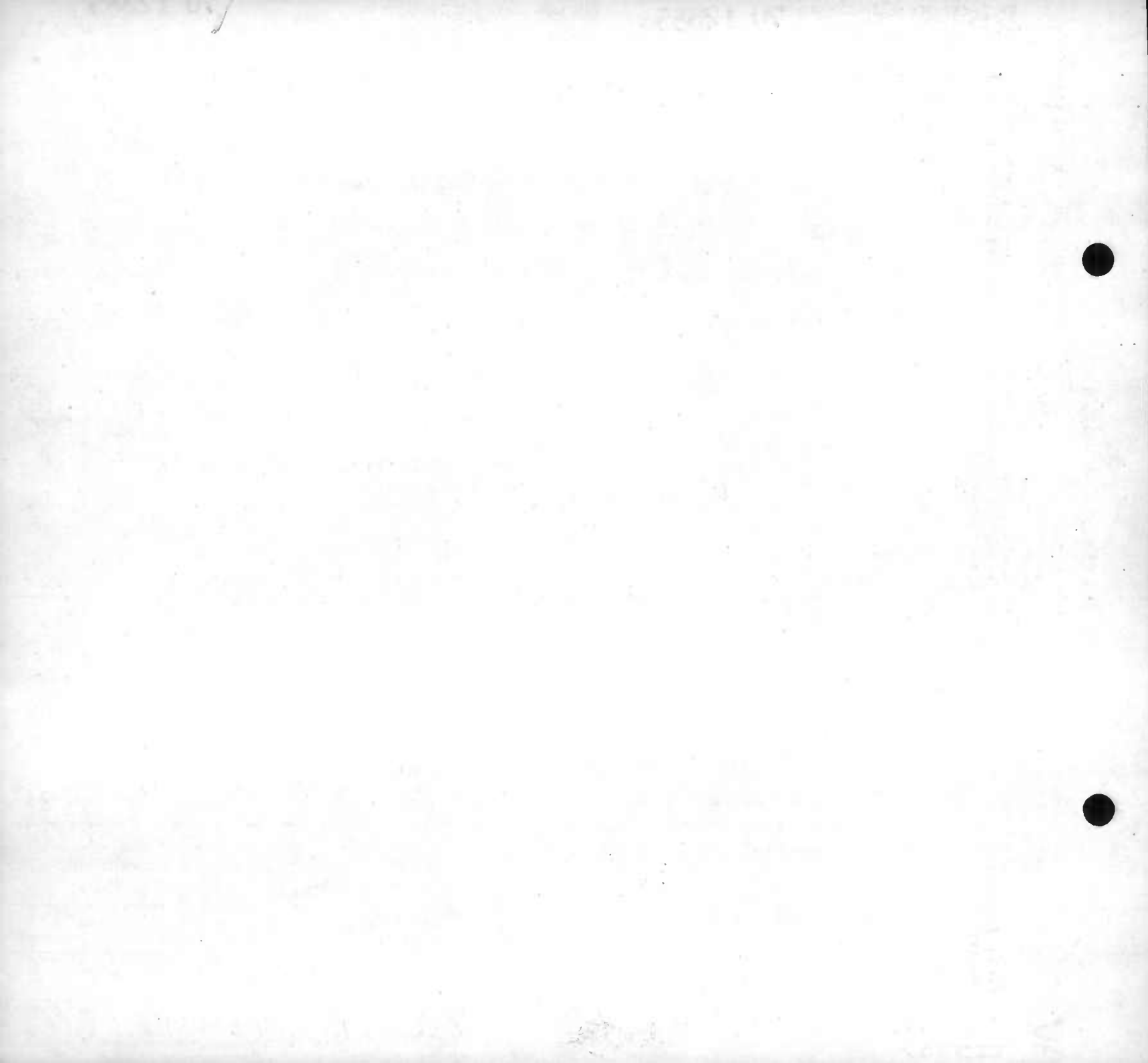
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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

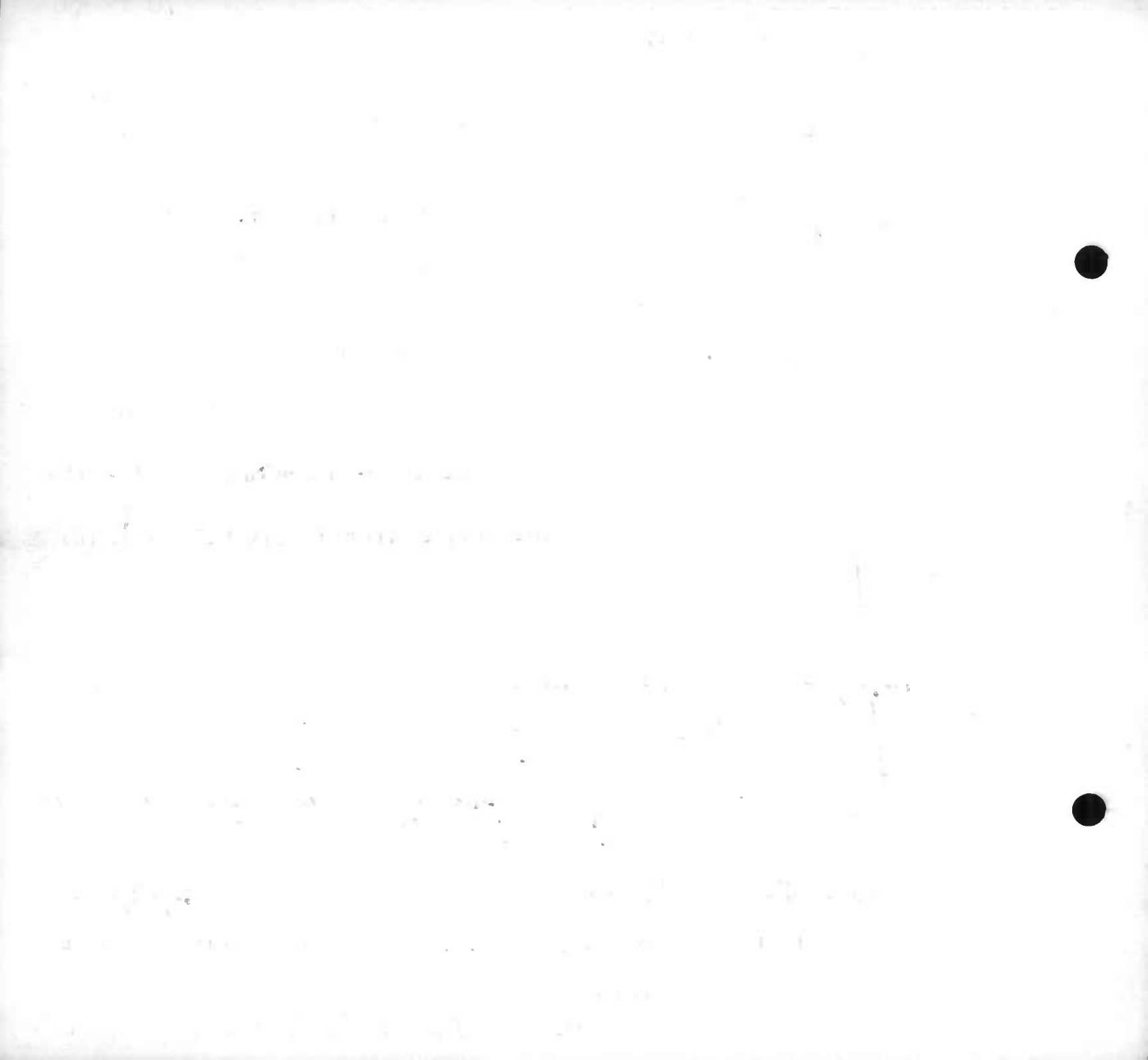
BALTIMORE CITY HEALTH DEPT. 12885				REG. NO. _____			
B-346 70 12885				<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>Edith Butler</b>				2. DATE AND HOUR OF DEATH <b>12-31-70 12:55 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> 8. COUNTY <b>605</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Century Nursing Home</b>				C. CITY OR TOWN <b>BAITD.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Female</b> 6. RACE <b>Negro</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>1-23-02</b>		9. AGE (In years last birthday) <b>68</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Thomas Hill</b>			
14. MOTHER'S MAIDEN NAME <b>Elizabeth Hill</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Evelyn Hudgins-3408 Piedmont Ave</b>			
18. <b>412.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardio-Respiratory Failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Hemorrhage (B) Hypertensive - Art. C.V.H.D. DUE TO OR AS A CONSEQUENCE OF: (C) Generalized Atherosclerosis</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Oct 6</b> 19 <b>70</b> to <b>Dec 31</b> 19 <b>70</b> , that (I) (we) last saw the deceased alive on <b>Dec 31</b> 19 <b>70</b> and that in (my) <b>(my)</b> opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did not) view the body after death.							
23A. SIGNATURE <b>Willard Appleford</b>				23B. DATE SIGNED <b>1/5/71</b>		23C. PHYSICIAN'S NAME (Type) <b>Willard Appleford</b>	
23D. ADDRESS <b>6615 Reisterstown Rd</b>				23E. FUNDAL DIRECTOR <b>ELLRIOTT Funeral Home-1129 N. Condit St</b>		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-6-71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Westport, Md.</b>	
25A. DATE REC'D. BY HEALTH DEPT. <b>JAN 7 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNDAL DIRECTOR <b>ELLRIOTT Funeral Home-1129 N. Condit St</b>		25D. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>W-435</u> <u>70 12886</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 12886</u>	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ANTHONY WALTON				12-29-70 9:10 PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE MARYLAND		B. COUNTY	
THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1908 E. OLIVER ST.			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-01-56	9. AGE (In years last birthday) 15	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME FRED WALTON JR.				14. MOTHER'S MAIDEN NAME MARY CARTER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Mary Walton - 1908 E. Oliver St.			
18. <u>395501</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CEREBRAL ICHHEMIA.		7 DAYS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) RHEUMATIC HEART DISEASE. DUE TO, OR AS A CONSEQUENCE OF:		5 YEARS	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 12/22/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED AORTIC VALVE DYSFUNCTION.		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) NO.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from DEC 22 19 70 to DEC 29 19 70 that (I) (we) last saw the deceased alive on DEC 29 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE William Easton Walker, M.D.				23B. DATE SIGNED 12/29/70		23C. PHYSICIAN'S NAME (Type) WILLIAM EASTON WALKER, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-2-71		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cem.		24D. LOCATION (City, town, or county) (State) A. A. County, Md.	
25A. DATE RECEIVED BY HEALTH DEPT. JAN 7 1971		25B. NAME OF REGISTRAR Robert E. Bailey, Jr.		25C. FUNERAL DIRECTOR E. H. F. H. 1129 N. Paulin St.		ADDRESS	



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## BALTIMORE CITY HEALTH DEPARTMENT

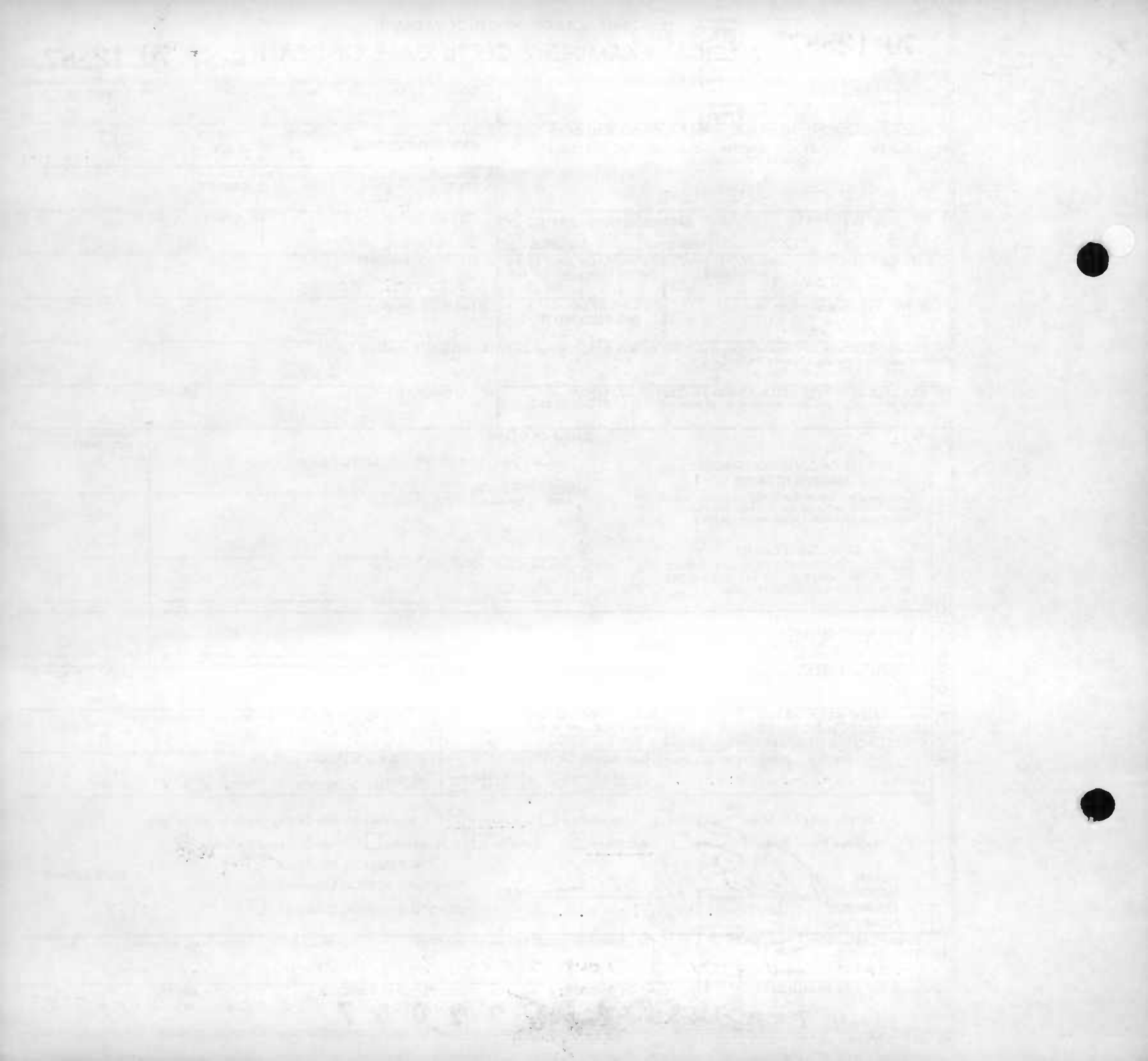
70 12887

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12887

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HELEN KEATON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 BON SECOURS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour December 31, 1970 9:05 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2101			
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 1-21-1934		10. AGE (In years lost birthday) 36	E. STREET AND NUMBER 772 Carroll Street
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Louis KEATON
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME MATTIE MADISON
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.	18. INFORMANT ADDRESS GLADYS KEATON 4019 WOODHAVEN AVE.
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E-8801 Multiple Traumatic Injuries		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 772 Carroll Street 2101		22F. HOW DID INJURY OCCUR? Subject jumped from 3rd floor window	
22D. TIME OF INJURY (APPROX.) 12-31-70 7:05 A.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1/1/71	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-5-71	
24C. NAME OF CEMETERY or CREMATORY ARBUTUS MEM. PARK		24D. LOCATION (City, town, or county) (State) ARBUTUS, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1971		25B. NAME OF REGISTRAR E. J. [unclear]	
25C. FUNERAL DIRECTOR CHARLES A. RICE		ADDRESS 661 W. BARRE ST.	



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## BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM STEWART</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) (DOA) <b>South Baltimore General Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>December 30, 1970 8:12 P. M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1001</b>	
9. DATE OF BIRTH <b>9-7-1957</b>		10. AGE (in years lost birthday) <b>13</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>		15. MOTHER'S MAIDEN NAME <b>ALICE DAVENPORT</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>NONE</b>	
18. INFORMANT <b>Edmond DAVENPORT 1102 E. BIDDLE ST.</b>		ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cerebro-vascular injuries</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>12-30-70 (?)</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>Injured during altercation</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>00-00</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12-31-70</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-6-71</b>	
24C. NAME OF CEMETERY or CREMATORY <b>MT. CALVARY</b>		24D. LOCATION (City, town, or county) (State) <b>BROOKLYN, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>CHARLES A. RICE</b>		ADDRESS <b>661 W. BARRE ST.</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12889	
70 12889					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>Charles F.W. Green</b>			2. DATE AND HOUR OF DEATH <b>12-30-1970 12:25 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>31 Baltimore City Hospitals 4940 Eastern Avenue 21224 Baltimore, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2102</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1357 Ward Street 21230</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-10-1901</b>	9. AGE (In years last birthday) <b>69</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charlie Green</b>			14. MOTHER'S MAIDEN NAME <b>Estella</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES NWI</b>		16. SOCIAL SECURITY NO. <b>213-09-7159A</b>		17. INFORMANT <b>Lacy Green - 1357 Ward St.</b> ADDRESS <b>Records: BCH 4940 Eastern Avenue 21224</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>1621 I</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Massive Left Pleural Effusion 10 days</b> (B) <b>Bronchogenic Carcinoma of Lung 3 months.</b> (C) _____		
19A. DATE OF OPERATION <b>2</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>Dec. 13, 1970</b> to <b>Dec. 30, 1970</b> that (1) (we) last saw the deceased alive on <b>Dec. 30, 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William P. Hunt M.D.</b>			23B. DATE SIGNED <b>Dec. 30, 1970</b>		23C. PHYSICIAN'S NAME (Type) <b>William P. Hunt</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>1-4-71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1971</b>			25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Charles A. Rice 661 W. Baver St.</b>

There is a great deal of  
work to be done in the  
field of research.

It is a great pleasure to  
have you here. I hope  
you will find it interesting.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12890	
BIRTH NO. 70 12890		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <i>ELLA BROWN</i>		2. DATE AND HOUR OF DEATH <i>12. 27. 1970</i> <i>9.45 a.m.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>1537</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Lutheran Hospital</i>		C. CITY OR TOWN <i>Baltimore Md.</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>2510 N. Ellomont St.</i>			
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9/11/1879</i>	9. AGE (In years last birthday) <i>91</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>	
13. FATHER'S NAME <i>Squire Smith</i>		14. MOTHER'S MAIDEN NAME <i>unk.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Andrew Brown Jr. 600 Round View</i>	
18. <i>174X I</i>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Advanced Cancer Breast</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Chronic Scholastic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) _____			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12. 26. 1970</i> 19 <i>70</i> to <i>12. 27. 1970</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>12. 27. 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>M. Elmer</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>12. 27. 1970</i>	
23C. PHYSICIAN'S NAME (Type) <i>MAMDOUH RASTOM GAGE</i>		23D. ADDRESS <i>Lutheran Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/31/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 1 1971</i>			
25B. NAME OF REGISTRAR <i>E. J. Bay, M.D.</i>		25C. FUNERAL DIRECTOR <i>Charles C. Rice 661 W. Borne St.</i>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12891	
1. NAME OF DECEASED (Type or Print) <b>MAMIE P. TURNER</b>		2. DATE AND HOUR OF DEATH <b>12-27-70 5 55 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>		A. STATE <b>MD</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY <b>BALTO.</b>		C. CITY OR TOWN <b>BALTIMORE</b>	
44		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>2710</b>	
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/27/22</b>	9. AGE (In years last birthday) <b>48</b>	10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.S.W.F.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>William Bass</b>		14. MOTHER'S MAIDEN NAME <b>Pearl Jenkins</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Robert C. Turner</b> <b>HOSPITAL CHART 508 E. 43rd St.</b>	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>CARCINOMA OF CERVIX</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>12/27/70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>12/27</b> 19 <b>70</b> to <b>12/27/70</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>12/27/70</b> 19 <b>70</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>Irving D. Wolfe, M.D.</b>		23B. DATE SIGNED <b>12-27-70</b>		23C. PHYSICIAN'S NAME (Type) <b>IRVING D. WOLFE, M.D.</b>	
23D. ADDRESS <b>UNION MEMORIAL HOSPITAL, BALTIMORE</b>		23E. DATE <b>12/30/70</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>		24C. LOCATION (City, town, or county) (State) <b>Arbutus, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 7 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Tabor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Charles A. Bero 661 W. Baltimore St.</b>	



S530

70 12892

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 12892

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ANNIE P. SMITH		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 806 W. Lexington St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 23 1970 10:35 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1801			
6. SEX female	7. RACE negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 6/15/1901	10. AGE (in years last birthday) 69	E. STREET AND NUMBER 806 W. Lexington St.	
11. BIRTHPLACE (State or foreign country) VIRGINIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME UNK.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME UNK.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	17. SOCIAL SECURITY NO.	18. INFORMANT C. Andrew Rice 663 W. Barre St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-23-70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/31/70	24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1971	25B. NAME OF REGISTRAR Robert E. Gailley, M.D.	25C. FUNERAL DIRECTOR Charles A. Rice	ADDRESS 661 W. Barre St.

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[Faint, mostly illegible text covering the main body of the page, possibly a ledger or record book. Some faint words like "Total" and "Grand Total" are visible.]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-423 70 12893		BALTIMORE CITY HEALTH DEPARTMENT		70 12893	
BIRTH NO.		FALKENSTEIN VIOLA		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
Type or Print		Viola E. Falkenstein		12/31/70 10:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital at institution, give street address or location)		Md. Baltimore 901	
48 Md. General Hospital		D. STREET ADDRESS (If rural, give location)		504 E. 41st St.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Female	White	WIDOWED, DIVORCED (specify) Widowed	2/21/1891	79	11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Homemaker				Baltimore	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Charles Farley		Virginia McCulloh		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
None				Arthur T. Mossey 3618 Deverne Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Fracture Left Clavicle			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
Approved		Home		504 E 41st St	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
12-18-70 3 P.M.		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		fell at home - fell down steps	
22. I certify that (this hospital) attended the deceased from		12/18 1970 to		12/31 1970	
that (I) (we) lost saw the deceased alive on		12/31 1970 and that in (our) opinion death occurred on the date		and hour and from the causes stated above. (We) (did) (did not) view the body after death.	
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Donald H. Dembo				12/31/70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
DR. DONALD H. DEMBO		MD. GENERAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/2/71		Loudon Park Cemt.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 7 1971		Robert E. Fisher, Jr.		Mitchell Wiedefeld Home 6500 York Rd.	

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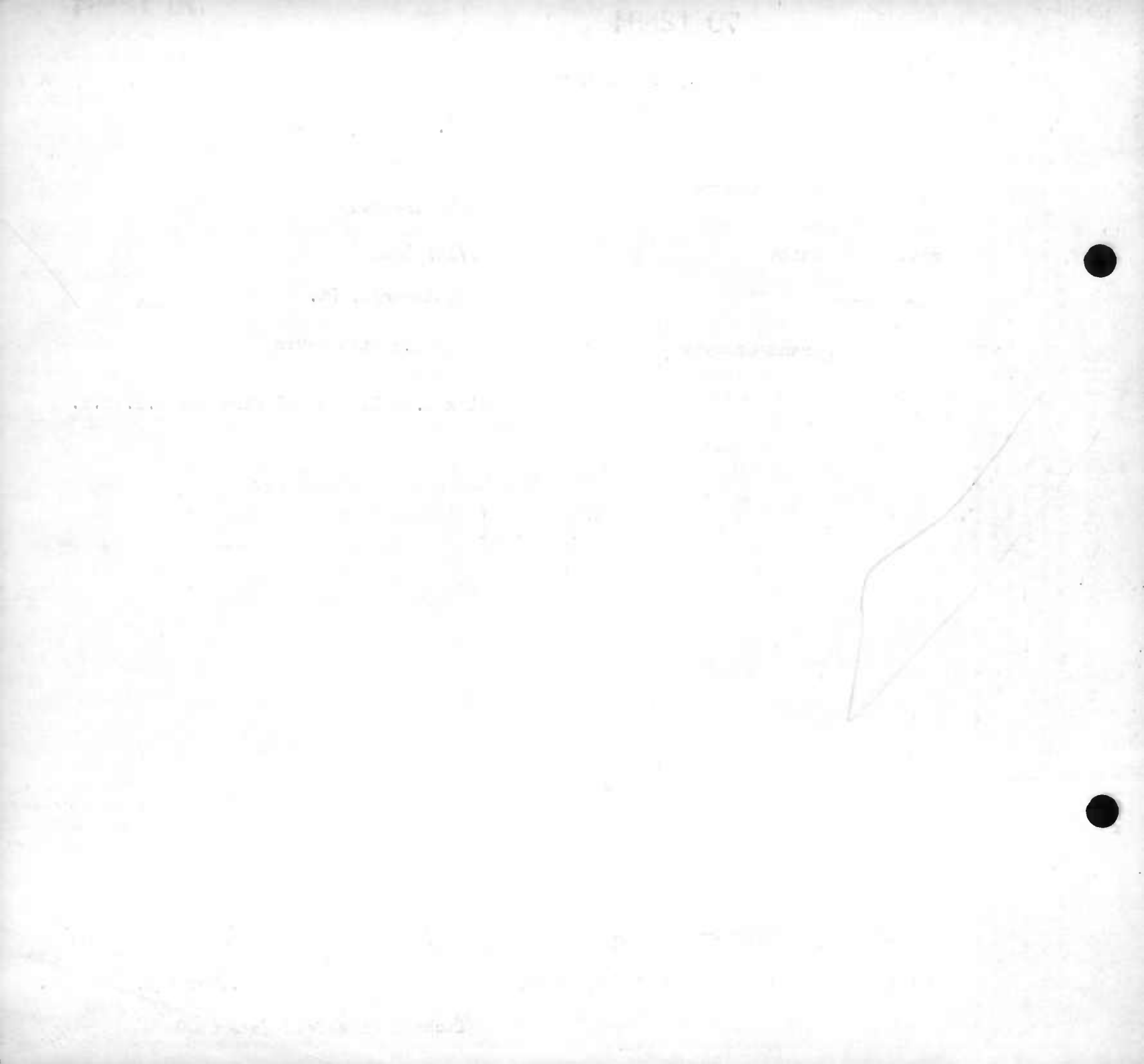
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH				3			
Romaine Le Moyne Billings				12/22/1970				A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				5			
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE				B. COUNTY			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Md.				Baltimore			
00 3405 Greenway				C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
				Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER							
				3405 Greenway							
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months Days	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		1/12/ 1882		88			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Homemaker								Pittsburgh, Pa.			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
USA				Frank LeMoyné				Lucretia Lewis			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
NA								Kirk L. Billings 200 Park Ave N.Y. N.Y.			
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Heart Disease							
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from 12/21/1970 to 12/20/1970, and that (I) (we) last saw the deceased alive on 12/21/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE								23B. DATE SIGNED			
A. Murray Fisher											
23C. PHYSICIAN'S NAME (Type)								23D. ADDRESS			
A. Murray Fisher								1907 Ruxton Rd/Ruxton, Md			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
Burial		12/26/70		Allegheny Cemetery		Pittsburgh, Pa.					
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS					
JAN 7 1971		Robert E. Fisher		Mitchell Wiedefeld Home 6500 York Rd Balto. Md.							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

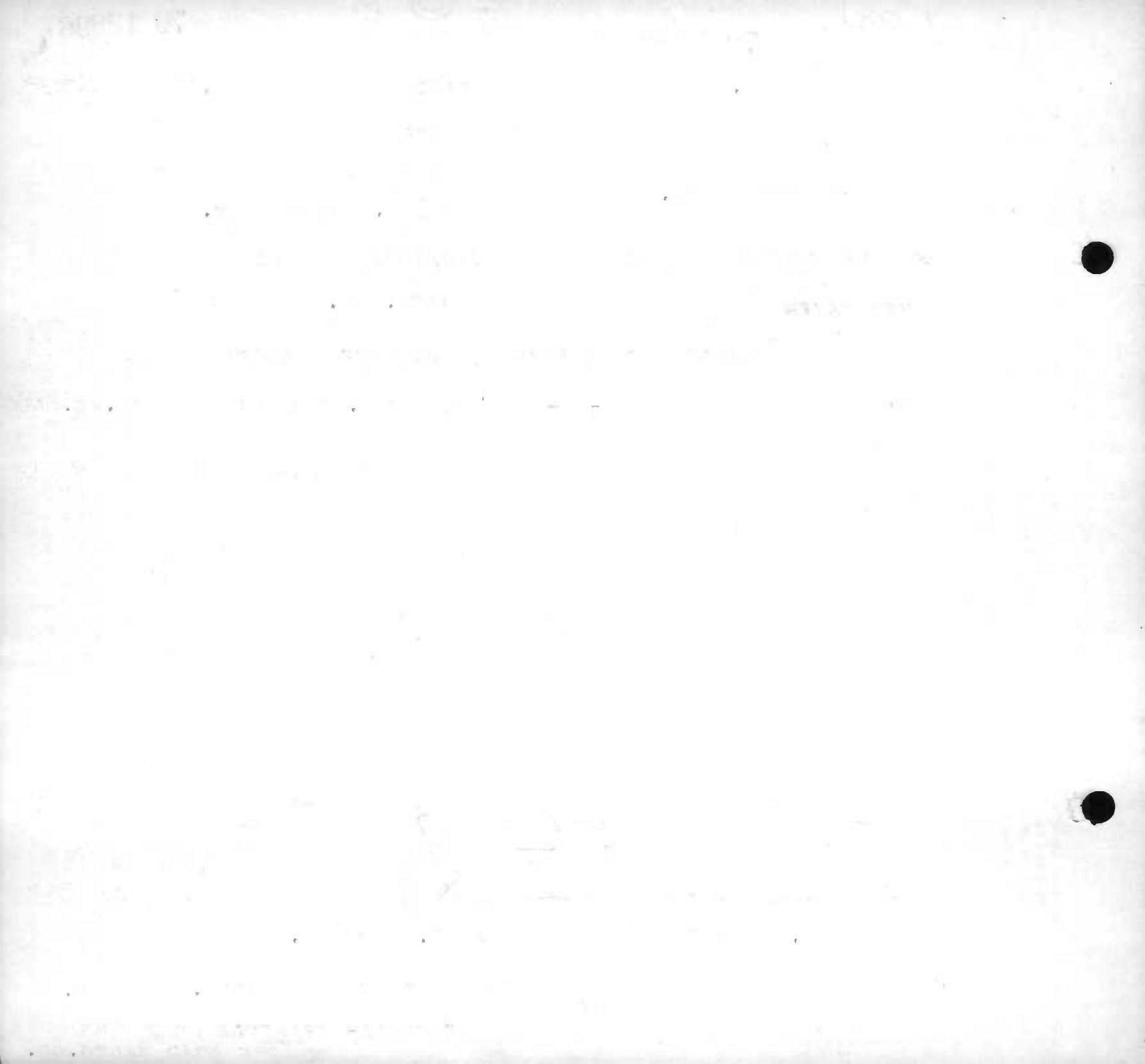
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">70 12895</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">W-000</span> <span style="font-size: 1.5em;">70 12895</span> </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>					
<div style="display: flex; justify-content: space-between;"> <div> <b>BIRTH NO.</b>            1. NAME OF DECEASED            (Type or Print) <span style="font-size: 1.1em;">Anita Louise Wey</span> </div> <div> <b>2. DATE AND HOUR OF DEATH</b>  <div style="border: 1px solid black; padding: 2px;">12/25/1970</div> </div> </div>				M.	
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <div style="display: flex; justify-content: space-between;"> <div> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>            (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   <div style="font-size: 1.2em;">4502 N. Charles Street</div> </div> <div> <b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)  <div style="display: flex; justify-content: space-between;"> <div> <b>A. STATE</b>            Md.         </div> <div> <b>B. COUNTY</b>            Baltimore         </div> </div> </div> </div>				<div style="font-size: 1.5em;">2711</div>	
<div style="display: flex; justify-content: space-between;"> <div> <b>5. SEX</b>            Female         </div> <div> <b>6. RACE</b>            White         </div> <div> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/>  <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> </div> </div>				<b>8. DATE OF BIRTH</b> <div style="border: 1px solid black; padding: 2px;">12/26/1929</div>	
<b>9. AGE</b> (In years last birthday) <div style="border: 1px solid black; padding: 2px;">41</div>				<b>If Under 1 Yr.</b> Months: Days: <b>If Under 24 Hrs.</b> Hours: Min.	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Sect.				<b>11. BIRTHPLACE</b> (State or foreign country) Baltimore, Md.	
				<b>12. CITIZEN OF WHAT COUNTRY?</b> USA	
<b>13. FATHER'S NAME</b> Oscar H. Wey				<b>14. MOTHER'S MAIDEN NAME</b> Clare Rosenberger	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) NO				<b>16. SOCIAL SECURITY NO.</b>	
				<b>17. INFORMANT ADDRESS</b> Mrs. Charles E. Carr 108 St. Dunstan Rd.	
<div style="display: flex; justify-content: space-between;"> <div> <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>            (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>            DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.         </div> <div> <b>CAUSE OF DEATH</b>            (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <div style="font-size: 1.5em;">Coronary Occlusion</div>           (B) <div style="font-size: 1.5em;">Extreme Occlusion A.T.S.</div>            DUE TO, OR AS A CONSEQUENCE OF:            (C)         </div> <div> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>   <div style="font-size: 1.5em;">6 yrs</div> </div> </div>					
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <div style="font-size: 1.2em;">June 1949</div> <b>19</b> <b>to</b> <div style="font-size: 1.2em;">Dec 15</div> <b>1970</b> , <b>that (I) (we) last saw the deceased alive on</b> <div style="font-size: 1.2em;">Dec 24</div> <b>19</b> <b>70</b> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <div style="font-size: 1.5em;">Charles E. Carr Jr.</div>				<b>23B. DATE SIGNED</b> <div style="font-size: 1.2em;">12/26/70</div>	
<b>23C. PHYSICIAN'S NAME</b> (Type) CHAS. E. CARR JR.				<b>23D. ADDRESS</b> <div style="font-size: 1.2em;">3900 N. CHAR. ST.</div>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) Burial		<b>24B. DATE</b> <div style="font-size: 1.2em;">12/28/70</div>		<b>24C. NAME OF CEMETERY or CREMATORY</b> New Cathedral Cent.	
		<b>24D. LOCATION</b> (City, town, or county) (State) Frederick Rd. Balto. Md.			
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <div style="font-size: 1.2em;">JAN 7 1971</div>		<b>25B. NAME OF REGISTRAR</b> <div style="font-size: 1.2em;">Robert E. Carr Jr.</div>		<b>25C. FUNERAL DIRECTOR ADDRESS</b> Mitchell Wiedefeld Home 6500 York Rd.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-500		70 12896		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12896	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		MRS. GRACE RICHARDSON LONEY		DECEMBER 30, 1970 8:50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		BALTIMORE			
00 Homewood Apts.		E. STREET AND NUMBER		3003 N. CHARLES ST.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	3/5/1879	91			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOMEMAKER				BALTO. MD.		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
CHARLES RICHARDSON		KATHERINE NORRIS POWELL					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		220-44-3793		HERBERT W. SCHAEFER 1st Nat. Bk. Bldg			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		H.C. V.D.		15 yr.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from 10/18 1956 to 12/30 1970 that (I) ( <del>we</del> ) last saw the deceased alive on 12/29 1970 and that in (my) ( <del>my</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE Norman R. Freeman		23B. DATE SIGNED 12/31/70		23C. PHYSICIAN'S NAME (Type) DR. NORMAN FREEMAN		23D. ADDRESS 11 W. 29TH ST.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
CREMATION		1/5/70		LOUDON PARK CREMATORY		BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 7 1971		Robert E. Taylor, M.D.		MITCHELL-WIEDEFELD HOME		6500 YORK ROAD BALTO. MD.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
W-365 70 12897					REG. NO. 70 12897					
CERTIFICATE OF DEATH										
BIRTH NO.										
1. NAME OF DECEASED (Type or Print) <u>Whitehorn, Miss Catherine L.</u>					2. DATE AND HOUR OF DEATH <u>12-30-70</u> <u>6<sup>35</sup></u> p.m.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>91 Keswick Home</u>					4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1307</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>700 W. 40th St.</u>					
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-5-1911</u>	9. AGE (in years last birthday) <u>59</u>	10. UNDER 1 Yr. Months: Days: Hours: Min.		11. UNDER 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Librarian Supervisor</u>					10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Columbus, Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Arthur Ray Whitehorn</u>					14. MOTHER'S MAIDEN NAME <u>Rhadora Wood</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>324-22-1188</u>		17. INFORMANT <u>Keswick Records - 700 W 40th ST</u>			
18. <u>4811</u> CAUSE OF DEATH										
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Cerebral arteriosclerosis; hypertension</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that <u>BT</u> (this hospital) attended the deceased from <u>MAY 21</u> 19 <u>70</u> to <u>Dec. 30</u> 19 <u>70</u> that <u>BT</u> (we) last saw the deceased alive on <u>12/30/70</u> 19 <u>70</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>BT</u> (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>W.B. Daniels, Jr.</u>					23B. DATE SIGNED <u>12/31/70</u>			23C. PHYSICIAN'S NAME (Type) <u>W.B. Daniels</u>		
23D. ADDRESS <u>700 W. 40th St.</u>					23E. DEGREE					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/2/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Reistertown Rd. Pikesville Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 7 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Vaden, R.D.</u>			25C. FUNERAL DIRECTOR <u>Mitchell Wiedefeld</u>			25D. ADDRESS <u>Home 6500 York Rd.</u>		

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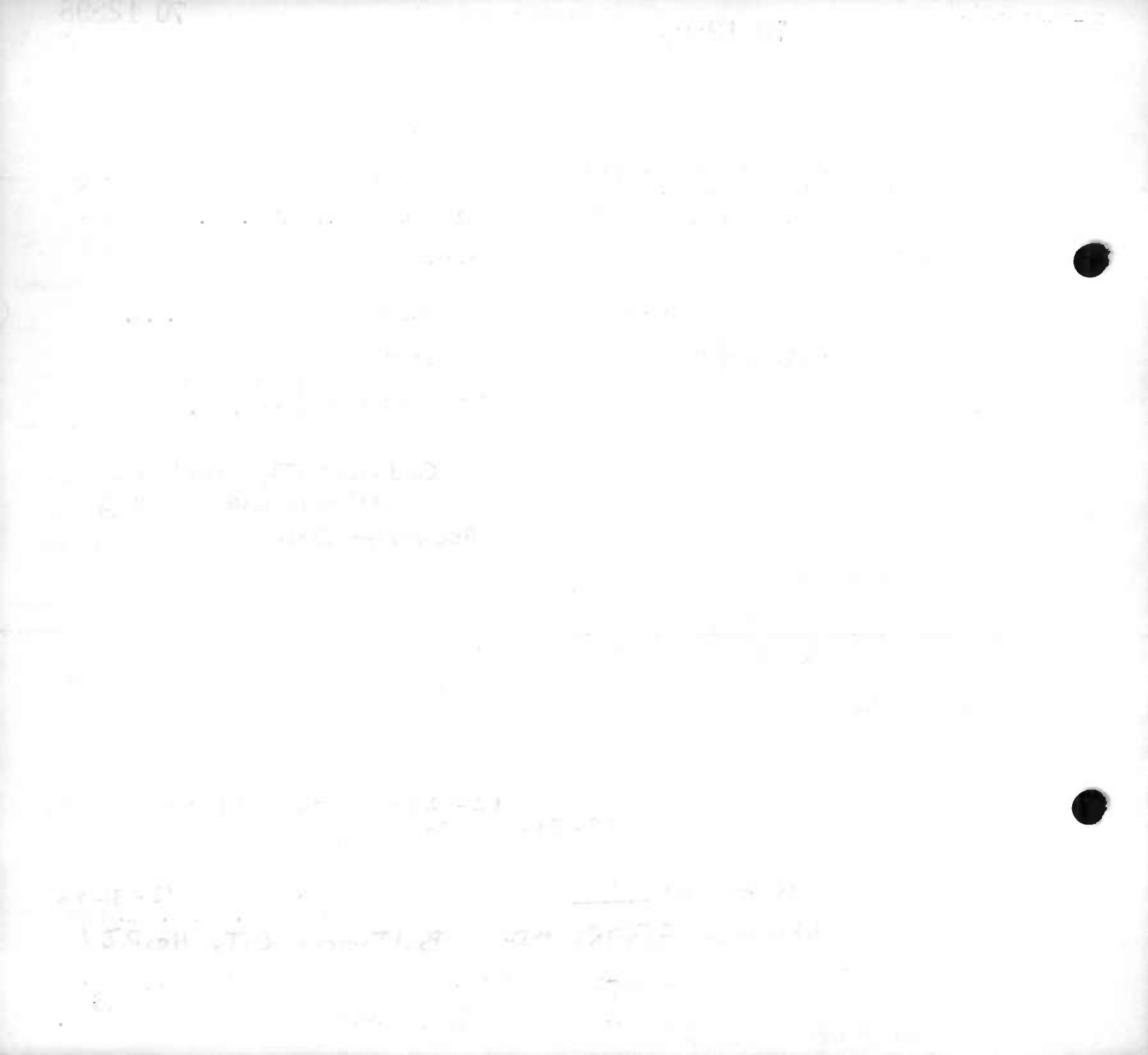
11-2-11

11-2-11

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-160 70 12898		BALTIMORE CITY HEALTH DEPARTMENT		70 12898	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO. X	
1. NAME OF DECEASED (Type or Print) <u>Schaffer, Virgie</u>			2. DATE AND HOUR OF DEATH <u>12-31-70 1:20 Pm.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>			A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <u>7168 Gough St., Balto. Md. 21224 005</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-17-90</u>	9. AGE (In years last birthday) <u>80</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Charles Crabill</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Combs</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>4940 Eastern Avenue</u> <u>BCH Records: Baltimore, Md. 21224</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiorespiratory arrest</u> <u>extensive CVA.</u> <u>ASCD &amp; DM.</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few min.</u> <u>2 days</u> <u>many yrs.</u>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-29-1970</u> to <u>12-31-1970</u> that (I) (we) last saw the deceased alive on <u>12-31-1970</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>K. AFSARI</u>			23B. DATE SIGNED <u>12-31-70</u>		
23C. PHYSICIAN'S NAME (Type) <u>Khosrow AFSARI M.D.</u>			23D. ADDRESS <u>4940 Eastern Ave. Balto. Md. 21224</u> <u>Baltimore City Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <u>Manassas Cmty.</u>	
24D. LOCATION <u>Manassas, Virginia.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 7 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Baker Funeral Home Manassas, Va.</u>	



1		70 12899		BALTIMORE CITY HEALTH DEPARTMENT	
S-420		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 70 12899	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>	
		MARIE SILLS		Month Day Year Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 30 1970 4:15 p M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY Maryland 302	
1141 E. Lombard St.					
6. SEX female	7. RACE negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday) 65		E. STREET AND NUMBER 1141 E. Lombard St.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) Acute cellulitis, right leg		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-1-70					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-7-71		24C. NAME OF CEMETERY OR CREMATORY ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1971		25B. NAME OF REGISTRAR Robert E. Kelly		25C. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	



70 12900

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 12900

BIRTH NO.

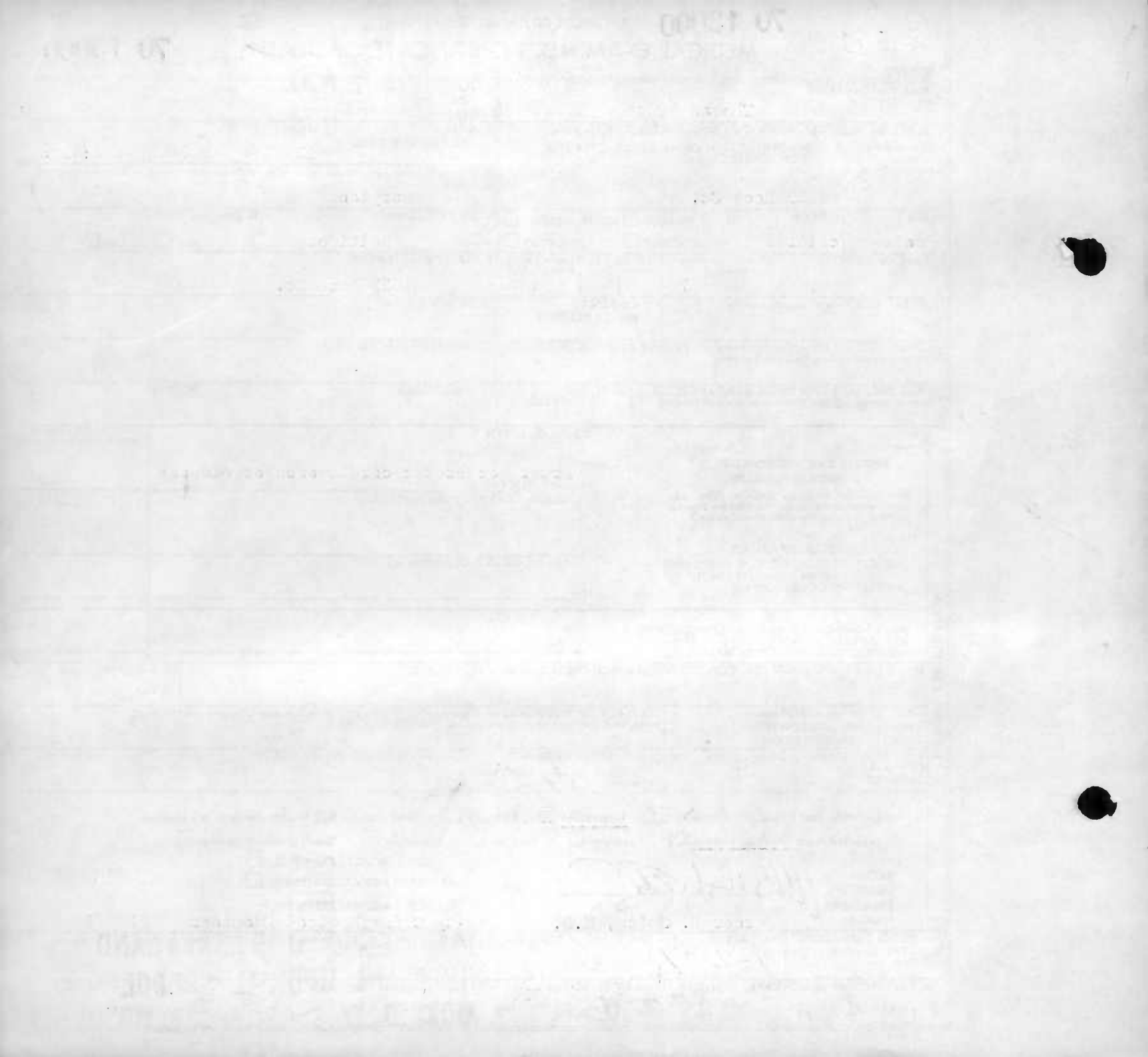
1. NAME OF DECEASED (Type or Print) Thomas Pitt		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 1023 Race St.		3. DATE PRONOUNCED DEAD Month 12 Day 4 Year 70		8:45 a.m.			
6. SEX male		7. RACE colored		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2301	
9. DATE OF BIRTH		10. AGE (In years lost birthday) 67		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS			

19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) NO	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/4/70	

24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-7-71		24C. NAME OF CEMETERY ANATOMY BOARD OF MARYLAND		24D. LOCATION (City, town or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1971		25B. NAME OF REGISTRAR Robert E. Sealey		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

I-236 1970 122901		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 1970 122901	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Estelle F. Foster</i>		2. DATE AND HOUR OF DEATH <i>12-29-70 9<sup>30</sup> AM</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>435 South Balt. Gen. Hospital</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md.</i> B. COUNTY <i>Balt city</i>		C. CITY OR TOWN <i>2710</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <i>915 Belgian Ave. md.</i>	
5. SEX <i>M</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-20-05</i>	9. AGE (in years last birthday) <i>65</i>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired nurse</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>CITY</i>		11. BIRTHPLACE (State or foreign country) <i>PENN.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Charles L. Hatch</i>		14. MOTHER'S MAIDEN NAME <i>Marie E. Byrne</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES WWII</i>		16. SOCIAL SECURITY NO. <i>244-405740</i>		17. INFORMANT <i>Dominic Sheet</i>	
18. <i>173.3 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Dehydration + Starvation</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma of nose</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 mos.</i> <i>2 yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>12-28-70</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>(X) YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12-28</i> 19 <i>10</i> to <i>12-29</i> 19 <i>70</i> that (I) (we) lost saw the deceased alive on <i>12-29</i> 19 <i>70</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Richard H. Reed MD</i>		23B. DATE SIGNED <i>12-29-70</i>		23C. PHYSICIAN'S NAME (Type) <i>REED</i>	
23D. ADDRESS <i>S 136 St</i>		23E. DEGREE <i>MD</i>		23F. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-31-70</i>		24C. NAME of CEMETERY or CREMATORY <i>Lorraine Park Cem</i>	
24D. LOCATION <i>Baltimore</i>		24E. (City, town, or county)		24F. (State) <i>md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 8 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Franklin Company Bldg. Catonsville Md.</i>	

Received 12-31-50  
Fidelity Guaranty Co. & Co. Baltimore Md

YES  
MM II

944-402440

10/1/50

-MARKS-

+

C 111

+

10/1/50

10/1/50

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

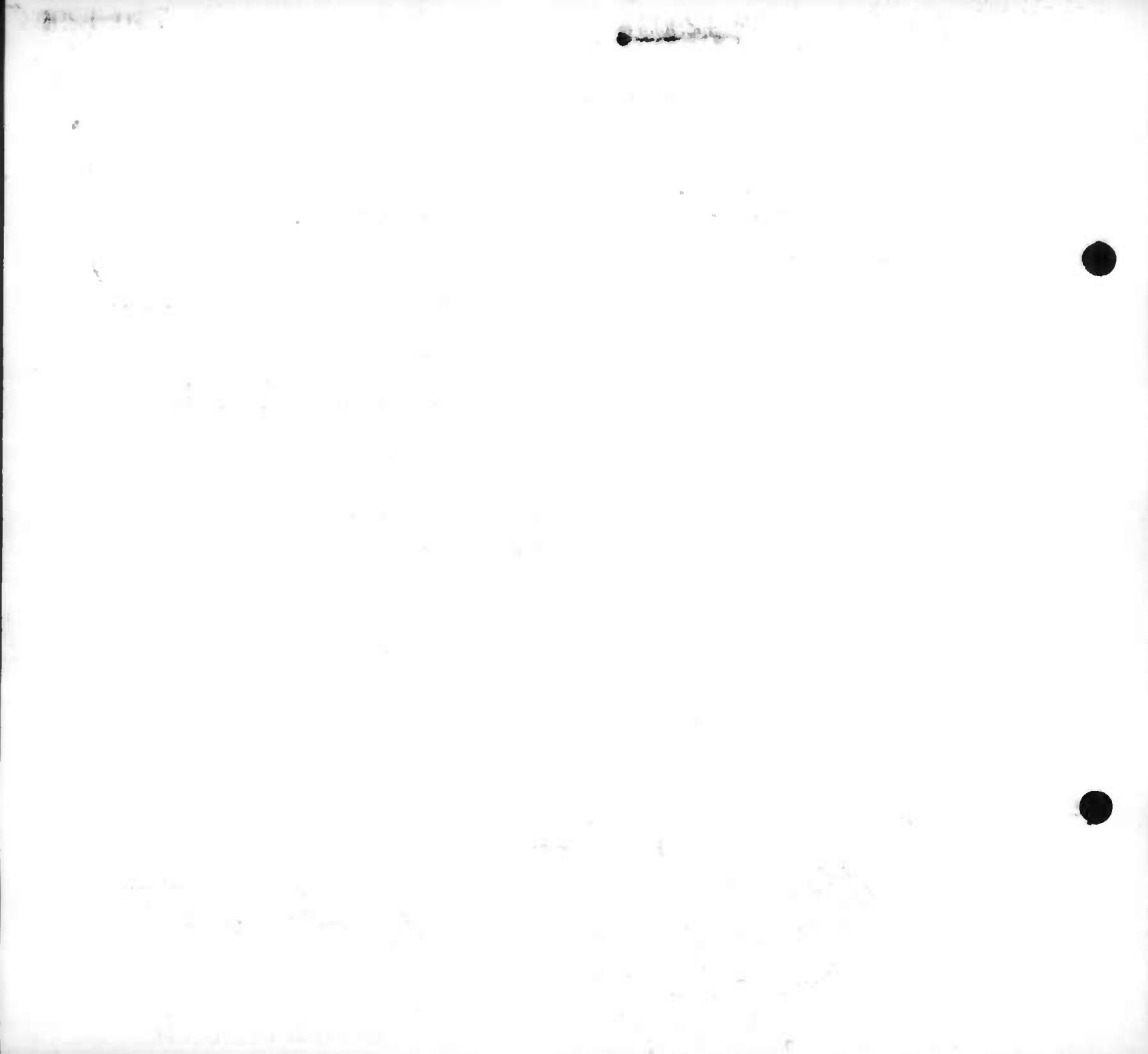
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 720 12902	
G-152 70-23513 70 12902 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <u>Givens baby girl Barbara</u>			2. DATE AND HOUR OF DEATH <u>December 24, 1970</u>   <u>6:30 P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>BALTIMORE CITY HOSPITALS</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4709 Homer Avenue</u> Apt. <u>2nd</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-24-70</u>	9. AGE (in years last birthday)	10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
13. FATHER'S NAME <u>James Carter</u>			14. MOTHER'S MAIDEN NAME <u>Barbara Givens</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>BCH: Records Baltimore, Maryland 21224</u>			18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>2</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>metabolic disorder</u> 20A. AUTOPSY (Yes or No) <u>Yes</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>prematurity</u> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>city Hospitals</u> 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>12/24</u> 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? <u>prematurity</u>		
22. I certify that (I) (this hospital) attended the deceased from <u>12/24</u> 19 <u>70</u> to <u>12/24</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>12/24</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Edoardo MAZZA</u> DEGREE			23B. DATE SIGNED <u>12/24/70</u>		
23C. PHYSICIAN'S NAME (Type) <u>Edoardo MAZZA</u> DEGREE			23D. ADDRESS <u>city Hospitals</u> <u>4940 Eastern Ave.</u> <u>Balto. Md. 21224</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>	24B. DATE <u>12-28-70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore City Hospitals</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland 21224</u>	25A. DATE REC'D BY HEALTH DEPT. <u>JAN 8 1971</u>	
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 770-12903	
P-623 70-23505		70-12903	
BIRTH NO. 70-23505		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Preston, baby boy</i>		2. DATE AND HOUR OF DEATH <i>12/25/70 6:45 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <i>209 Germanhill Rd. 21222 005</i>	
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-25-70</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>15</i>
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Preston</i>		14. MOTHER'S MAIDEN NAME <i>Sandra Adey</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>4940 Eastern Ave.,</i> ADDRESS <i>BCH Records: Baltimore, Md. 21224</i>
18. <i>742X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) <i>Hydrocephaly</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Hydrocephaly</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <i>12-29-70</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY (Yes or No) <i>Yes</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/25</i> 19 <i>70</i> to <i>12/25</i> 19 <i>70</i> that <i>(I)</i> (we) last saw the deceased alive on <i>12/25</i> 19 <i>70</i> and that in <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>(I)</i> (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Mezzari</i>		23B. DATE SIGNED <i>12-25-70</i>	
23C. PHYSICIAN'S NAME (Type) <i>Eduardo Mezzari</i>		23D. ADDRESS <i>4940 Eastern Ave. 21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>	24B. DATE <i>12-29-70</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore City Hospitals</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland 21224</i>
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 8 1971</i>	25B. NAME OF REGISTRAR <i>Robert E. Taylor, Jr.</i>	25C. FUNERAL DIRECTOR <i>HOSPITAL DISPOSAL</i>	



## CERTIFICATE OF DEATH

REG. NO.

77012904 X

BIRTH NO. 70-23309

1. NAME OF DECEASED  
(Type or Print)

Tolbert, Baby girl, Delphine

2. DATE AND HOUR OF DEATH

12/25/70 8 30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Baltimore City Hospitals  
4940 Eastern Ave.,  
Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE  
Maryland  
C. CITY OR TOWN  
Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

917 Rutland Ave. 21205 007

5. SEX

Female

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12-25-70

9. AGE (In years  
last birthday)If Under 1 Yr. Months Days  
If Under 24 Hrs. Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Delphine Ann Tolbert

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT 4940 Eastern Ave., ADDRESS  
BCH Records: Baltimore, Md. 21224

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH[This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.]

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐ Not While  
Work At Work ☐

21F. HOW DID INJURY OCCUR

22. I certify that (this hospital) attended the deceased from 12/25 1970 to 12/25 1970  
that (we) last saw the deceased alive on 12/25 1970 and that (we) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

12-25-70

23C. PHYSICIAN'S  
NAME (Type)

23D. ADDRESS

4940 Eastern Ave. Baltimore, Md.  
2122424A. BURIAL CREMATION,  
REMOVAL (Specify)24B. DATE  
12-28-7024C. NAME OF CEMETERY OR CREMATORY  
Baltimore City Hospitals24D. LOCATION (City, town, or county) (State)  
Baltimore, Maryland 21224

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JAN 8 1971

HOSPITAL DISPOSAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Report of the  
Committee on  
the State of the  
Union

Attest  
1874

Wm. A. Rorer  
Secretary

Washington, D.C.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12905

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

EDITH BUCHANAN

2. DATE  
OF DEATHKnown ☒ Estimated ☐Month Day Year  
December 30, 1970

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 1903 Mc Henry Street

3. DATE  
PRONOUNCED DEADMonth Day Year  
December 30, 1970

Hour

11:00 P.  
M.

5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE Maryland

B. COUNTY

2003

6. SEX

Female

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

1-9-25

10. AGE (In years  
last birthday)

46

11. Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1903 Mc Henry Street

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

GEORGE C. COX

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

OPERATOR

14B. KIND OF BUSINESS OR INDUSTRY

VENTILATION BLIND

15. MOTHER'S MAIDEN NAME

UNKNOWN

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

NONE

17. SOCIAL  
SECURITY NO.

210-12-3611

18. INFORMANT

Roland Evans - 1903 Mc Henry St. Md 21230

ADDRESS

BALTO

19. E-985-X

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Gunshot wound of chest  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1903 Mc Henry Street

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.) 12-30-70 10:00 P.22E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Apparently shot self in chest

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 31, 1970

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

1-7-71

24C. NAME OF CEMETERY or CREMATORY

NEW CATHEDRAL

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JAN 12 1971

26.6 E 712.720 0 0 0

26.8 E 712.720 0 0 0

NO 1585

RECEIVED

1-4-25  
MA  
U.S.A.  
George C. Cox

Director  
United Blind  
Unknown

10-12-25  
10-12-25

ACADEMIC BOARD

1-4-25

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-636 70 12906 BIRTH NO. 70 12906		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 96870 12906	
1. NAME OF DECEASED (Type or Print) <u>Carter James</u>			2. DATE AND HOUR OF DEATH <u>12/17/70</u> <u>6P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>George Washington Nursing Home</u> <u>607 Pennsylvania Ave</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE _____ B. COUNTY _____ C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>830 Harlem Ave</u>		
5. SEX <u>male</u>	6. RACE <u>negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/14/1897</u>	9. AGE (in years last birthday) <u>73</u>	If Under 1 Yr. Months _____ Days _____ If Under 24 Hrs. Hours _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor work</u>		10B. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Chesterfield Co. Va.</u>	
13. FATHER'S NAME <u>Joseph Carter</u>			14. MOTHER'S MAIDEN NAME <u>Amanda Carter</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>216-05-6243A</u>		17. INFORMANT <u>Chart</u> ADDRESS _____	
18. <u>16211</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARCINOMA OF LUNG</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____ 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____ 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? _____ 22. I certify that (1) (this hospital) attended the deceased from <u>8-23-1970</u> to <u>12-17-1970</u> that (1) (we) last saw the deceased alive on <u>12-15-1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. 23A. SIGNATURE <u>Richard Tyson, MD</u> 23B. DATE SIGNED <u>12-17-70</u> 23C. PHYSICIAN'S NAME (Type) <u>Richard Tyson, MD</u> 23D. ADDRESS <u>936 W. North Avenue</u> 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>12/27/70</u> 24C. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cr</u> 24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 11 1971</u> 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> 25C. FUNERAL DIRECTOR <u>10820</u> ADDRESS _____					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-645		70 12907		BALTIMORE CITY HEALTH DEPARTMENT		70 12907			
BIRTH NO.				REG. NO.					
1. NAME OF DECEASED (Type or Print) <b>FREELAND ALFRED</b>				2. DATE AND HOUR OF DEATH <b>12-27-70 101:30A</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO</b>					
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY OF MD. HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>38 BALTO. 21201</b>		C. CITY OR TOWN <b>BALTO.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <b>M</b>		6. RACE <b>N.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1916</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) <b>54</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
18. <b>134.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Aspiration PNEUMONIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>GASTRIC DILATATION</b> <b>CA RETURN Hepate</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>CA RETURN Hepate</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 HRS.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>11-16-70</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CARCINOMA RECTUM</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>12-8-70</b> to <b>12-27-70</b> and that (I) (we) last saw the deceased alive on <b>12-27-70</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>H. S. RANGANATH</b>				23B. DATE SIGNED <b>12/27/70</b>		23C. PHYSICIAN'S NAME (Type) <b>H. S. RANGANATH</b>			
24A. BURIAL CREMATION, ETC. (Specify) <b>Burial</b>		24B. DATE <b>1/9/71</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MT Calvary Cemetery</b>		24D. LOCATION (City, town or county) (State) <b>BALTO MD 21201</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 12 1971</b>		25B. NAME OF REGISTRAR <b>Adolphus Halstead</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W North Ave</b>			

217 E. Fayette St.

Adm. 6/15/68

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 12908	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Eleanor Sellman</u>		2. DATE AND HOUR OF DEATH <u>12/28/70 8:55 AM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>35 South Baltimore General Hospital</u>		A. STATE <u>MD</u> B. COUNTY <u>Balt. City</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1213 LIGHT ST.</u> <u>1207</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1882</u>	9. AGE (in years last birthday) <u>88</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>?</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-07-4893-D</u>		17. INFORMANT ADDRESS	
18. <u>429.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiovascular Collapse</u> (B) <u>Volume Depletion</u> (C) <u>Severe Dehydration</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>?</u> <u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/27</u> 19 <u>70</u> to <u>12/28</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>12/27</u> 19 <u>70</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Colvin C. Carter, M.D.</u>		23B. DATE SIGNED <u>12-28-70</u>		23C. PHYSICIAN'S NAME (Type) <u>Colvin C. Carter M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burned</u>		24B. DATE <u>12/31/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Moravia + Belair Rd Balto Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 12 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>	
25C. FUNERAL DIRECTOR <u>Wm. J. Tucker + Sons Balto Md.</u>		25D. ADDRESS			

520 W. 27th St. 21212

Adm. 9/16/70

H-400

70 12909

BALTIMORE CITY HEALTH DEPARTMENT

70 12909

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) George William Hoal		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 27 Year 70 Hour 3:50 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital		3. DATE PRONOUNCED DEAD Month 12 Day 27 Year 70 Hour 3:50 p.m.	
6. SEX male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE Md. B. COUNTY 2428 Eutaw Place 1301	
9. DATE OF BIRTH 3/20/1921		10. AGE (In years last birthday) 49	
11. BIRTHPLACE (State or foreign country) Lynchburg VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George M. Hoal Sr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER	
15. MOTHER'S MAIDEN NAME Ellie White		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	

19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wounds of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	--

20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET		22C. WHERE DID IT IN BALTIMORE CITY, GIVE EXACT LOCATION) 1200 blk. of Whitelock Street 1303	
22D. TIME OF INJURY (APPROX.) Month 12 Day 27 Year 70 3:30 p.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject was shot by an assailant while being robbed.	

23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE Peter Lipkovic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		12/28/70	
EXAMINER'S NAME (Type)		ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>			

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/5/71		24C. NAME OF CEMETERY or CREMATORY Nat'l Park Service		24D. LOCATION (City, town, or county) (State) Bethesda PA	
25A. DATE REC'D BY HEALTH DEPT. JAN 12 1971		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Wm. J. Dehner + Sons Inc		ADDRESS	

N87511



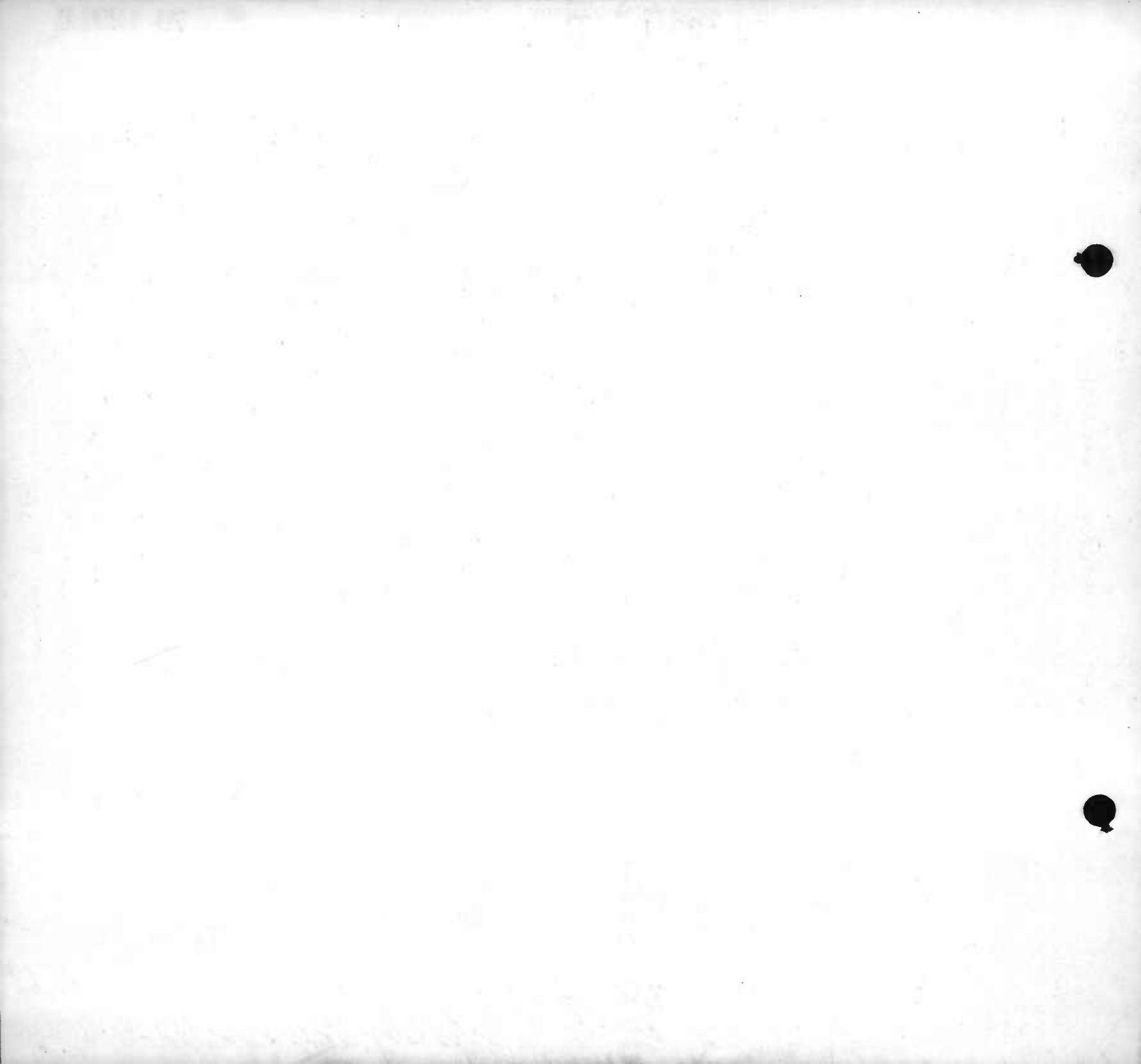
BIRTH NO.		70 12910 BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 70 12910	
1. NAME OF DECEASED (Type or Print) <b>ALFONSO RULE</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1603 Light Street</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 30, 1970 1:45 P.M.</b>			
6. SEX <b>Male</b>				7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Aug. 21, 1896</b>				10. AGE (In years lost birthdate) <b>74</b>		11. BIRTHPLACE (State or foreign country) <b>Philippines</b>	
12. CITIZEN OF <b>USA</b>				13. FATHER'S NAME <b>unk</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2404</b>	
15. MOTHER'S MAIDEN NAME <b>unk</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Deato Alvez</b>				19. ADDRESS <b>2746 E. Baltimore St</b>			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>0</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) <b>No</b>							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?				22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>December 31, 1970</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/12/71</b>		24C. NAME of CEMETERY or CREMATORY <b>Sacred Heart Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Dundalk Balto Co Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 15 1971</b>		25B. NAME OF REGISTRAR <b>Charles E. Springate</b>		25C. FUNERAL DIRECTOR <b>McCall F.H. 130 E Fort ave</b>		ADDRESS <b>211230</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12911	
<p>W-426 70 12911</p> <p>BIRTH NO. 70 22362</p> <p>1. NAME OF DECEASED (Type or Print) <b>BABY BOY PATRICK WALKER</b></p> <p>2. DATE AND HOUR OF DEATH <b>12-17-70</b></p>					
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <b>MARYLAND</b></p> <p>B. COUNTY <b>WINCHESTER</b></p> <p>C. CITY OR TOWN <b>BALTIMORE</b></p> <p>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>2406 Winchester St. 1605</b></p>			<p>5. SEX <b>Male</b></p> <p>6. RACE <b>Negro</b></p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>8. DATE OF BIRTH <b>12/19/70</b></p> <p>9. AGE (In years lost birthday) <b>28</b></p> <p>10. If Under 1 Yr. Months <b>28</b> Days <b>12</b></p> <p>11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b></p> <p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>		
<p>13. FATHER'S NAME <b>Jeffrey Walker</b></p> <p>14. MOTHER'S MAIDEN NAME <b>MARGIE</b></p> <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b></p> <p>16. SOCIAL SECURITY NO. <b>None</b></p> <p>17. INFORMANT <b>Medical records</b></p>			<p>18. <b>726-11</b></p> <p>CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Kyphine Membrane Rupture</b></p> <p>(B) <b>Prematurity</b></p> <p>(C) _____</p>		
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> <p>19A. DATE OF OPERATION <b>0</b></p> <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____</p> <p>20A. AUTOPSY? (Yes or No) _____</p> <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____</p>					
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p> <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p> <p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____</p> <p>21F. HOW DID INJURY OCCUR? _____</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>12/17</b> 19 <b>70</b> to <b>12/18</b> 19 <b>70</b>, that (I) (we) last saw the deceased alive on <b>12/18/70</b> 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <b>Josephine G. Brunidos</b></p> <p>23B. DATE SIGNED <b>12/18/70</b></p> <p>23C. PHYSICIAN'S NAME (Type) <b>Josephine G. Brunidos, M.D.</b></p> <p>23D. ADDRESS <b>Lutheran Hosp. of Maryland</b></p>				<p>24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b></p> <p>24B. DATE <b>12-19-70</b></p> <p>24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary</b></p> <p>24D. LOCATION (City, town, or county) (State) <b>Cedarhill Md.</b></p>	
<p>25A. DATE REC'D. BY HEALTH DEPT. <b>JAN 15 1971</b></p>		<p>25B. NAME OF REGISTRAR <b>Wesley Chavis Jr.</b></p>		<p>25C. FUNERAL DIRECTOR <b>Edmondson</b></p>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-520 70 12912		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 12912	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) James VERNON		2. DATE AND HOUR OF DEATH Dec. 25 1970 11 25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore County		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 39 PROVIDENT HOSP.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10B. KIND OF BUSINESS OR INDUSTRY Baltimore County Club		8. DATE OF BIRTH 3-5-40	
13. FATHER'S NAME Charles Albert James		14. MOTHER'S MAIDEN NAME Ruth Butts		9. AGE (In years last birthday) 30	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 223-52-6719		17. INFORMANT Hercules James	
18. 52201 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Neurogenic Shock		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Hemorrhagic Pancreatitis		ADDRESS 2528 Edmond Cir	
19. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec. 25 1970 to Dec. 25 1970 that (I) (we) last saw the deceased alive on Dec. 25 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ophelia G. Pool, M.D.		23B. DATE SIGNED Dec. 26, 1970		23C. PHYSICIAN'S NAME (Type) OFELIA G. POOL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-29-70		24C. NAME of CEMETERY or CREMATORY Mt. Calvary	
25A. DATE REC'D BY HEALTH DEPT. JAN 15 1971		25B. NAME OF REGISTRAR Charles E. Jones		25C. FUNERAL DIRECTOR Wesley Harris	
24D. LOCATION (City, town, or county) (State) North Laurel Co. Md.		24E. ADDRESS 1922 Edmond Cir			

Unable to locate this address  
Coded to Lenny St in Balto. City

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CALVIN MC LEAN

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
HOSPITAL ADDRESS OR LOCATION)  
OR INSTITUTION

33 Johns Hopkins Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Md.

802

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

10.10.27

10. AGE (In years  
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

2311 E. Lafayette St.

11. BIRTHPLACE (State or foreign country)

D.C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Henry McLean

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Labor

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Frances McLean

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Lucille McLean 1927 Cath St

19.

E887X

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Bronchopneumonia  
DUE TO, OR AS A CONSEQUENCE OF:ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) subdural hematoma  
DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Street 13

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Around 1745 N. Duncan St.

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

12 12 70 11 P

22E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

Fell while intoxicated

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-23-70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1/8/71

24C. NAME of CEMETERY or CREMATORY

Gettysburg. Nat.

24D. LOCATION (City, town, or county)

Gettysburg. Penna.

25A. DATE REC'D BY HEALTH DEPT.

JAN 18 1971

25B. NAME OF REGISTRAR

R. E. F. B. 0 0 2

25C. FUNERAL DIRECTOR

L. B. C. 1927 Cath St

ADDRESS

443-1383

Letter from M.E.'s office

1-18-71

M.H.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>CLAYTON A. BRAUN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Md. Gen. Hos.</b>		3. DATE PRONOUNCED DEAD		Month	Day	Year	Hour
(If not in hospital or institution, give street address or location)		12 23 1970 10 a		M.			
5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE		B. COUNTY		1204	
Md.							
6. SEX male	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (in years lost birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
46		1					
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS	
19. <b>441.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(A) IMMEDIATE CAUSE Cardiac tamponade DUE TO, OR AS A CONSEQUENCE OF:							
(B) ruptured aortic aneurysm DUE TO, OR AS A CONSEQUENCE OF:							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)		partial	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23.		I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-23-70	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-12-71		24C. NAME OF CEMETERY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1971		25B. NAME OF REGISTRAR Robert E. Fairbank		ANATOMY BOARD OF MARYLAND UNIVERSITY SYSTEM MEDICAL SCHOOL MORTUARY SERVICE - BCHD			

NO 15014

NO 15014

NO 15014



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Names of grand-parents shown

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12915	
G-36210-23164 12915				CERTIFICATE OF DEATH	
BIRTH NO. [REDACTED]		1. NAME OF DECEASED (Type or Print) BABY BOY GATERS		2. DATE AND HOUR OF DEATH 12-25-70 7:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		1603	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MARYLAND HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12-25-70		9. AGE (In years last birthday) 1		10. If Under 1 Yr. Months Days 13	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME LEON GATERS		14. MOTHER'S MAIDEN NAME HESTER JAMES 715 FULTON ST.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT ADDRESS	
18. 726.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RESPIRATORY FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) IMMATURITY DUE TO, OR AS A CONSEQUENCE OF:			
(C) -					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 25 19 70 to Dec 25 19 70 that (I) (we) last saw the deceased alive on Dec 25 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] MD		23B. DATE SIGNED 12/25/70		23C. PHYSICIAN'S NAME (Type) EDWARD H. CAHILL MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 1-15-71		24C. NAME OF CEMETERY or CREMATOR	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1971		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR [Signature]	
24D. LOCATION (City, town, or county) BALTIMORE		24E. LOCATION (State) MARYLAND		24F. LOCATION (Country) U.S.A.	
ANATOMY BOARD OF MARYLAND					
JOHNS HOPKINS MEDICAL SCHOOL					
MORTUARY SERVICE - BCHO					

~~SECRET~~

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12916</u>
<div style="display: flex; justify-content: space-between;"> <span><u>J-525</u></span> <span><b>BIRTH NO.</b> <u>90-23481 70 12916</u></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>				
<b>1. NAME OF DECEASED</b> <small>(Type or Print)</small> <u>BABY GIRL JENKINS</u>			<b>2. DATE AND HOUR OF DEATH</b> <u>12/31/70</u> <u>6 A</u> M.	
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <div style="display: flex; justify-content: space-between;"> <div> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>  <u>University of Maryland Hospital</u> </div> <div> <b>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</b>  </div> </div>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div> <b>A. STATE</b>  <u>MARYLAND</u> </div> <div> <b>B. COUNTY</b>  <u>2101</u> </div> </div>	
<b>5. SEX</b> <u>F</u>			<b>6. RACE</b> <u>N</u>	
<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <u>12/30/70</u>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>CHICD</u>			<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>	
<b>13. FATHER'S NAME</b> 			<b>14. MOTHER'S MAIDEN NAME</b> <u>JOITWELL</u>	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> <small>(Yes, no or unknown) (If yes, give war or dates of service)</small> <u>No</u>			<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>	
<b>17. INFORMANT</b> <u>MOTHER</u>			<b>ADDRESS</b> <u>612 WHAMBERG ST. BALTO, Md.</u>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> <u>777X I</u>			<b>CAUSE OF DEATH</b> <u>Prematurity</u>	
<b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <u>9 1/2 hrs</u>	
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
<b>19A. DATE OF OPERATION</b> 		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> 		<b>20A. AUTOPSY?</b> (Yes or No)
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>12/30</u> <b>19</b> <u>70</u> <b>to</b> <u>12/31</u> <b>19</b> <u>70</u> <b>that (I) (we) last saw the deceased alive on</b> <u>12/31</u> <b>19</b> <u>70</u> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <u>Ruth S. Ashman, M.D.</u>			<b>23B. DATE SIGNED</b> <u>12/31/70</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>Ruth S. Ashman, M.D.</u>			<b>23D. ADDRESS</b> <u>University of Maryland Hospital</u>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> 		<b>24B. DATE</b> <u>1-15-71</u>		<b>24C. NAME of CEMETERY</b> 
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JAN 18 1971</u>				
<b>25B. NAME OF REGISTRAR</b> <u>Red E. [unclear]</u>				
<b>25C. FUNERAL DIRECTOR</b> 				

**ANATOMY BOARD OF MARYLAND**  
**JOHNS HOPKINS MEDICAL SCHOOL**  
**MORTUARY SERVICE - BCMD**

612 W. Hamburg St.

B-650  
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 12917

1. NAME OF DECEASED (Type or Print) REGINALD BROWN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET HOSPITAL ADDRESS OR LOCATION) 2313 Pennsylvania Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 6 1970 9:20 a M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH May 26, 1925		10. AGE (in years lost birthday) 45	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes Aug. 7, 1943-4-11-44		17. SOCIAL SECURITY NO. 43-12-6205	
13. FATHER'S NAME Benjamin Brown		15. MOTHER'S MAIDEN NAME Altermese Land	
18. INFORMANT Altermese Brown		ADDRESS 557 Presstman St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-14-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-16-71	
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Arbutus, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1971		25B. NAME OF REGISTRAR Robert E. Bailey	
25C. FUNERAL DIRECTOR Vernon E. Bailey		ADDRESS 1348 N. Calhoun	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 12918</u>
1. NAME OF DECEASED (Type or Print) <u>Michele Dawn Jones</u>		2. DATE AND HOUR OF DEATH <u>December 20 1970 2:10 P. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South Baltimore General Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> Prince George 6600 C. CITY OR TOWN <u>Laurel</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>308 Marshall Ave</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/30/70</u>	9. AGE (in years last birthday) <u>13</u> 40 Mins.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Richard Thomas Jones</u>		14. MOTHER'S MAIDEN NAME <u>Lois Teen Ramey</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mother</u> ADDRESS <u>308 Marshall Ave.</u>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Anoxia at birth</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Prematurity</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>—</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>13 1/2 hrs.</u> <u>13 1/2 hrs.</u>
19A. DATE OF OPERATION <u>—</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>
22. I certify that (I) (this hospital) attended the deceased from <u>12/20</u> 19 <u>70</u> to <u>12/20</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>12/20</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Mayurke Khongcharoensuk, M.D.</u>		23B. DATE SIGNED <u>12/20/70</u>		23C. PHYSICIAN'S NAME (Type) <u>MAYURKE KHONGCHAROENSUK M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>1-18-71</u>		24B. DATE <u>1-18-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>South Baltimore General Hospital Balto. Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u>		

**ANATOMY BOARD OF MARYLAND**  
**UNIVERSITY MEDICAL SCHOOL**  
**MORTUARY SERVICE - BCHD**



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 12919	
CERTIFICATE OF DEATH				REG. NO. _____	
1. NAME OF DECEASED (Type or Print) <b>Baby Girl McElveen</b>		2. DATE AND HOUR OF DEATH <b>12/22/70 12:35 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Balto. Gen'l. Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Balt. Md.</b> B. COUNTY <b>Childs Ct.</b> C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3429 Childs Ct. Balt. Md.</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-20-70</b>	9. AGE (In years last birthday) <b>2</b>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Newborn</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <b>Jane McElveen</b>		12. CITIZEN OF WHAT COUNTRY? <b>US A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>3429 Child Ct</b>	
18. <b>776.21</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Partial Atelectasis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (At stating the UNDERLYING CONDITION last.) <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <b>12/22/70</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/20 1970</b> to <b>12/22 1970</b> that (I) (we) last saw the deceased alive on <b>12/22 1970</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Charles L. Moore MD</b>				23B. DATE SIGNED <b>12/22/70</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1-18-71</b>		24C. NAME OF CEMETERY OR CREMATORY	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Selby, Jr.</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12920	
<p><b>CERTIFICATE OF DEATH</b></p>					
<p>BIRTH NO. 70-33742</p>		<p>1. NAME OF DECEASED (Type or Print) <i>Peacock, Baby Girl</i></p>			
<p>2. DATE AND HOUR OF DEATH <i>12-21-70 9:00 PM</i></p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>			
<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <i>MD</i> B. COUNTY <i>15-10</i></p>		<p>5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Lutheran Hospital</i></p>			
<p>C. CITY OR TOWN <i>Baltimore</i></p>		<p>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>			
<p>E. STREET AND NUMBER <i>Ashtabula St</i></p>		<p>6. SEX <i>F</i> 7. RACE <i>N</i> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>			
<p>9. DATE OF BIRTH <i>12-21-70</i></p>		<p>10. AGE (In years last birthday) <i>24</i></p>		<p>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <i>24</i></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country)</p>	
<p>12. CITIZEN OF WHAT COUNTRY?</p>		<p>13. FATHER'S NAME <i>Nathanial PEACOCK</i></p>		<p>14. MOTHER'S MAIDEN NAME <i>Johnnie Smith</i></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT ADDRESS</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Respiratory</i></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>					
<p>19A. DATE OF OPERATION <i>0</i></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <i>Yes</i></p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>21F. HOW DID INJURY OCCUR?</p>		<p>22. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <i>J. R. ...</i></p>		<p>23B. DATE SIGNED</p>		<p>23C. PHYSICIAN'S NAME (Type) <i>J. R. ...</i></p>	
<p>23D. ADDRESS</p>		<p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>1-25-71</i></p>			
<p>24B. DATE</p>		<p>24C. NAME OF CEMETERY</p>		<p>24D. NAME OF CEMETERY</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1971</i></p>		<p>25B. NAME OF REGISTRAR <i>R. E. ...</i></p>		<p>25C. NAME OF REGISTRAR</p>	
<p>25D. ADDRESS</p>		<p>ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</p>			

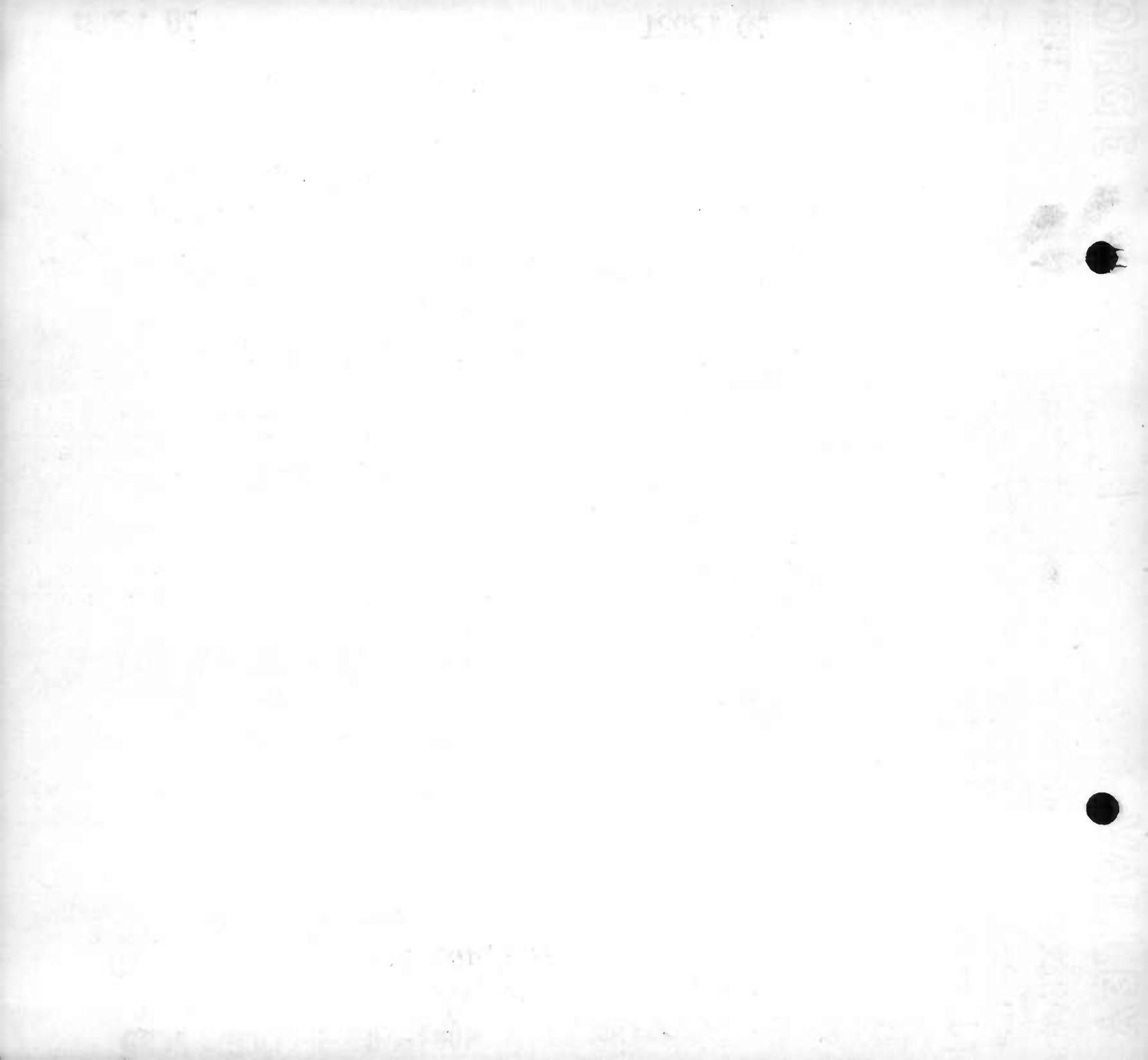
2 hrs old

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such deceased approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>70 12921</b>	4
N-242 70 12921		CERTIFICATE OF DEATH			
BIRTH NO. <b>70 22733</b>		1. NAME OF DECEASED (Type or Print) <b>NICHELLE NICOLE NICHOLSON</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <b>12-28-70 7:20 p</b> M.			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>21201 Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <b>FEMALE</b> 6. RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-28-70</b> 9. AGE (In years last birthday) <b>4</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>	
13. FATHER'S NAME <b>Paul Nicholson</b>		14. MOTHER'S MAIDEN NAME <b>Heblie Siebor</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <b>777 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Prematurity</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-28-70</b> to <b>12-28-70</b> , that (I) (we) last saw the deceased alive on <b>12-28-70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>P. G. NAGESHARAN</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-28-70</b>	
23C. PHYSICIAN'S NAME (Type) <b>P. G. NAGESHARAN</b>		23D. ADDRESS <b>Rutman Hosp. 730 Ashburn St. Balto</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1-25-71</b>		24C. NAME OF CEMETERY OR LOCATION (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1971</b>		25B. NAME OF REGISTRAR <b>333 E. E. 2nd</b>			

**ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BCND**



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BABY GIRL BANKS

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐Month  
Day  
Year

12-17-70

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
HOSPITAL ADDRESS OR LOCATION)  
OR INSTITUTIONSouth Baltimore General Hospital ☒3. DATE  
PRONOUNCED DEADMonth  
Day  
Year  
December 17, 1970

Hour

1:00 P. M.

5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)

A. STATE

Maryland

B. COUNTY

2532

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

10. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.  
2

E. STREET AND NUMBER

1110 Cherry Hill

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Immaturity (weight 640 grams)  
DUE TO, OR AS A CONSEQUENCE OF:ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)22E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK ☐ AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 23, 1970

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATOR

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BCHD

1. 2

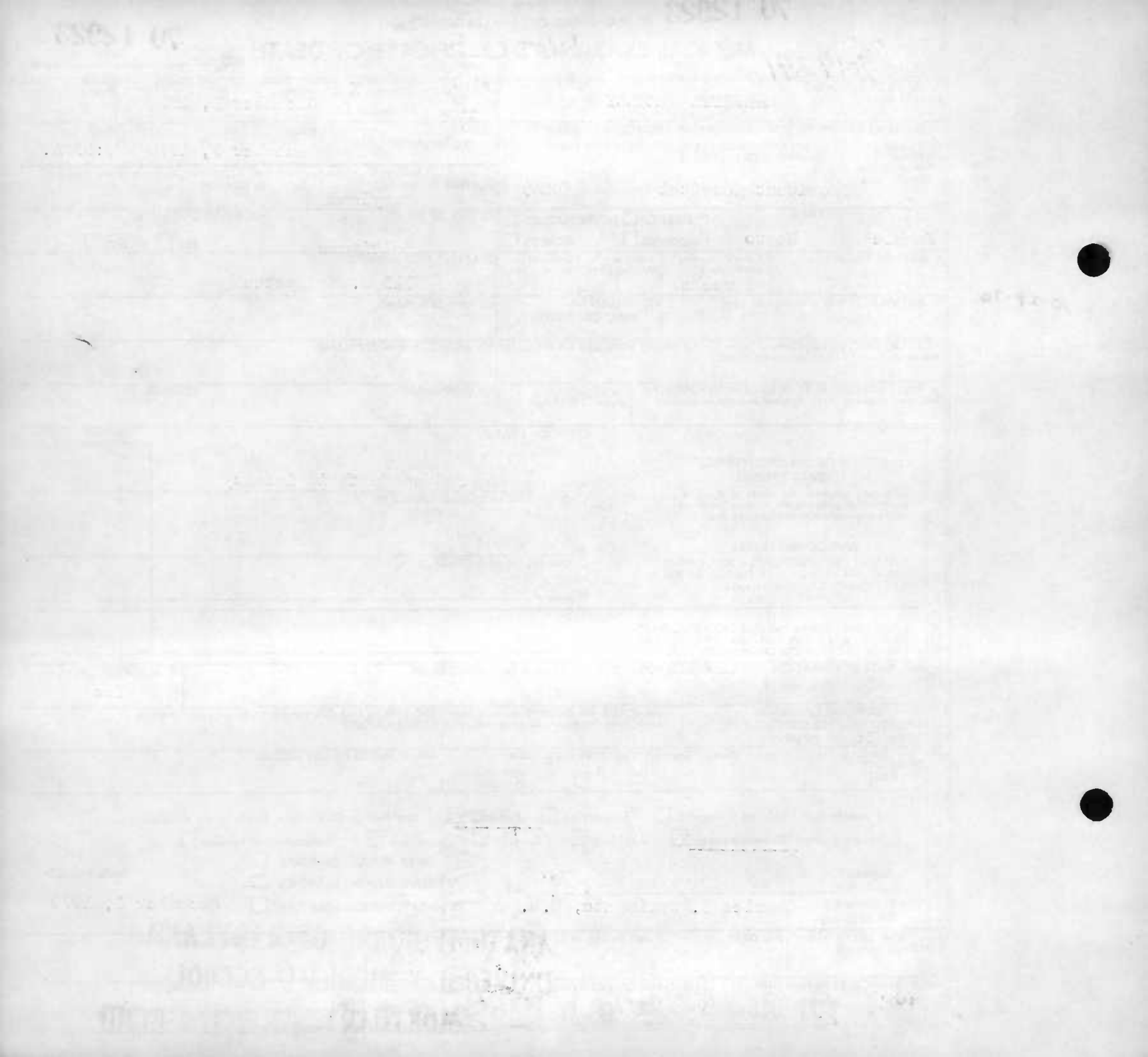
1 1999

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 7019241REG. NO. 70 12923

1. NAME OF DECEASED (Type or Print) <b>HARVETTA KELLY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <u>December</u> Day <u>3</u> , Year <u>1970</u> Hour <u>9:33</u> A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month <u>December</u> Day <u>3</u> , Year <u>1970</u> Hour <u>9:33</u> A. M.	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1703</b>	
9. DATE OF BIRTH <u>11-04-28</u>		10. AGE (In years lost birthday) <b>5 weeks</b>	
11. BIRTHPLACE (State or foreign country) <b>Ann</b>		12. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME <b>Lorraine</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. <b>795 X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Sudden death in infancy DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <u>Charles S. Springate</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>December 3, 1970</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>1-26-71</u>	
24C. NAME OF CEMETERY		24D. LOCATION (City, county or State) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>FEB 3 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BCHD



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12924

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John C. Nuckolls		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 S. Broadway		3. DATE PRONOUNCED DEAD		Month	Day	Year	Hour
				12	8	70	12:30 a.m.
6. SEX male		7. RACE white		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 202	
9. DATE OF BIRTH		10. AGE (in years lost birthday) 43		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
				15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
				17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	

19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		
(A) IMMEDIATE CAUSE Acute bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF:		
(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Fatty alteration of liver		

20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner	
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 12/8/70	

24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-26-71		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or village) (State)	
25A. DATE REC'D BY HEALTH DEPT. FEB 3 1971		25B. NAME OF REGISTRAR Robert E. Fisher		ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD			

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M-600

70 12925 BALTIMORE CITY HEALTH DEPARTMENT

70 12925

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Benjamin F. Moore		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2228 Madison Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 5 70 12:15 P.M.	
6. SEX male		7. RACE colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1303	
9. DATE OF BIRTH		10. AGE (In years last birthday) 60	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, near unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/5/70			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-26-71	
24C. NAME OF CEMETERY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. FEB 3 1971		25B. NAME OF REGISTRAR	

ANATOMY BOARD OF MARYLAND

UNIVERSITY MEDICAL SCHOOL

MORTUARY SERVICE - BCHO

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S-530

70 12926

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 12926

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Robert Lee Smith		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 11 Day 29 Year 70 Hour 1:05 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 9 West Preston Street		3. DATE PRONOUNCED DEAD Month 11 Day 29 Year 70 Hour 1:05 p.m.	
6. SEX male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) approx. 50		E. STREET AND NUMBER 9 West Preston Street	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cirrhosis of liver ANTecedent CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes (HeadP)			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. (Head Only) I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. EXAMINER'S NAME (Type): CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED: 11/30/70			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-26-71	
24C. NAME OF CEMETERY OR CREMATOR		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. FEB 3 1971		25B. NAME OF REGISTRAR Robert E. Talley, M.D.	

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BCHD

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# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 12927

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>EDWARD MC MAHON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1803 Eutaw Place</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 4 1970 6:35 p.m.</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH <b>10/7/7</b>	
10. AGE (In years last birthday) <b>61</b>		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. <b>532.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Duodenal perforation with generalized peritonitis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
22. (C) DUE TO, OR AS A CONSEQUENCE OF:			
23. DATE OF OPERATION		24. AUTOPSY? (Yes or No) <b>yes</b>	
25. CONDITION FOR WHICH OPERATION WAS PERFORMED			
26. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
29. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
31. HOW DID INJURY OCCUR?			
32. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
33. ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b>		34. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12-5-70</b>	
35. BURIAL CREMATION, REMOVAL (Specify)		36. DATE <b>12-6-71</b>	
37. NAME OF CEMETERY OR CREMATOR		38. LOCATION (City, town or county) (State)	
39. DATE REC'D BY HEALTH DEPT. <b>FEB 9 1971</b>		40. NAME OF REGISTRAR <b>Robert E. Fisher</b>	

VS 151-REV. 3/1/68

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BCTD

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>EDWARD EVANS</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>520 Laurens Street</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 9, 1970 9:05 A.M.</b>			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1403</b>							
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years lost birthday) <b>46</b>	11. BIRTHPLACE (State or foreign country)		E. STREET AND NUMBER <b>520 Laurens Street</b>		
		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS			
19. <b>011.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH <b>Pulmonary Tuberculosis</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) <b>no</b>							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12/9/70</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1-26-71</b>		24C. NAME of CEMETERY or CREMATORY <b>ANATOMY BOARD OF MARYLAND</b>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>FEB 9 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>UNIVERSITY MEDICAL SCHOOL</b>		25D. ADDRESS <b>MORTUARY SERVICE - BCHO</b>	

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70 12929 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12929

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LEONARD WEITZEL</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>719 Grundy Street</b>		3. DATE PRONOUNCED DEAD December 30, 1970		11:30 A.			
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2201</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>115 Churchill Street</b>			
9. DATE OF BIRTH		10. AGE (In years lost birthday) <b>51</b>		11. BIRTHPLACE (State or foreign country)			
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME				14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. <b>345.7 + 980.3</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Epilepsy</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Overdose of Dalmane</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>House</b>		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? <b>719 Grundy Street</b>			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>12-29-70 P.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Unk.</b>			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12/30/70</b>							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1-26-71</b>		24C. NAME OF CEMETERY or CREMATORY <b>ANATOMY BOARD OF MARYLAND</b>		24D. LOCATION (City, town, etc.) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>FEB 9 1971</b>		25B. NAME OF REGISTRAR <b>UNIVERSITY MEDICAL SCHOOL</b>		25C. FUNERAL DIRECTION <b>MORTUARY SERVICE - BCHD</b>			

N 855,1



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 58-16-90 12930	
J-250 70 12930 BIRTH NO. 23539		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Girl Jackson Genevieve		2. DATE AND HOUR OF DEATH 12-24-70 2:15 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Ave., Baltimore, Md. 21224		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Baltimore C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3709 Towanda Ave. 21215 007	
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-23-70
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 1 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Genevieve	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT 4940 Eastern Ave. ADDRESS BCH Records: Baltimore, Md. 21224			
18. 746.81 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE S-V Block. DUE TO, OR AS A CONSEQUENCE OF: (B) Respiratory System Syndrome. DUE TO, OR AS A CONSEQUENCE OF: (C) Prematurity, Discontinuity. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2/2/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/23 1970 to 12/24 1970 that (we) lost saw the deceased alive on 12/24 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE MAZZI		23B. DATE SIGNED 12/24	
23C. PHYSICIAN'S NAME (Type) Dr. Mazzi MD		23D. ADDRESS 4940 Eastern Ave. Baltimore, Md. Baltimore City Hospitals 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation	24B. DATE 12-28-70	24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21224
25A. DATE REC'D BY HEALTH DEPT. FEB 8 1971	25B. NAME OF REGISTRAR	25C. FUNERAL HOME	25D. ADDRESS



A-536

70 12931

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 12931

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Arnold Anderson</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2642 Maryland Ave.</b>		3. DATE PRONOUNCED DEAD		Month	Day	Year	Hour
				12	22	70	7:00 a. M.
6. SEX male		7. RACE white		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>12-06</b>	
9. DATE OF BIRTH		10. AGE (In years last birthday) <b>48</b>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
				15. MOTHER'S MAIDEN NAME			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give year or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS	

19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Fatty alteration of liver</b> DUE TO, OR AS A CONSEQUENCE OF:
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:

20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12/22/70</b>
EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
		Deputy Chief Medical Examiner		

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <b>12-9-71</b>	24C. NAME OF CEMETERY <b>ANATOMY BOARD OF MARYLAND</b>	24D. LOCATION (City, State or foreign country) (State)
25A. DATE REC'D BY HEALTH DEPT. <b>FEB 18 1971</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
VS 151-REV. 1/1/68			

UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BCHD

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U.S. DEPT. OF AGRICULTURE  
WASHINGTON

18-9-11

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

James Harris

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38 University Hospital

6. SEX

male

7. RACE

colored

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

10. AGE (In years last birthday)  
6711. Under 1 Yr. 11 Under 24 Hrs.  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?2. DATE OF DEATH  
Known ☒ Estimated ☐

Month Day Year Hour

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

12

26

70

4:00

p.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

14-03

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

E. STREET AND NUMBER

522 Lawrence St.

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Fracture of spine  
DUE TO, OR AS A CONSEQUENCE OF:ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

chronic alcoholism

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
home22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?  
522 Lawrence St.22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)  
12 25 70 6:30p m.22E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☒22F. HOW DID INJURY OCCUR?  
fell down stairs

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Deputy Chief Medical Examiner

12/27/70

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

2-9-71

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

FEB 18 1971

522 Laurens St.

8-9-11

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		6. CITY OR TOWN		7. INSIDE CITY LIMITS?	
EMMA RICHMOND		Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year		12 19 1970		12:45 p.m.		Md.		18-01	
17 N. Amity St.		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
65													
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS							
19. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		fatty liver		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
		ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) CHRONIC ALCOHOLISM DUE TO, OR AS A CONSEQUENCE OF:									
		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)									
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)		PARTIAL							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?									
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?									
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
		24A. DATE REC'D. BY HEALTH DEPT.		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
FEB 18 1971		24A. DATE REC'D. BY HEALTH DEPT.		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
VS 151-REV. 1/1/68		24A. DATE REC'D. BY HEALTH DEPT.		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					

ANATOMY BOARD OF MARYLAND

UNIVERSITY MEDICAL SCHOOL

MORTUARY SERVICE - BCHD

20051 US

COAST GUARD

UNITED STATES COAST GUARD

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11-28

BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12934

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LOTTIE LANE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Bon Secours Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 24 1970 9:15 p. M.</b>	
6. SEX <b>female</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birthday) <b>39</b>		E. STREET AND NUMBER <b>1316 Lawrence St.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	

19. <b>431.9 I</b> CAUSE OF DEATH <b>Intracerebral and subarachnoid hemorrhage</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:			

20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12-25-70</b>	
		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			

24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12-9-71</b>		24C. NAME OF CEMETERY or CREMATORY <b>ANATOMY BOARD OF MARYLAND</b>		24D. LOCATION (City, town or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>FEB 18 1971</b>		25B. NAME OF REGISTRAR <b>Page E. Fisher</b>		25C. NAME OF FUNERAL DIRECTOR <b>UNIVERSITY MEDICAL SCHOOL</b>		25D. NAME OF MORTUARY SERVICE <b>MORTUARY SERVICE - BCHD</b>	

REST OF

REST OF

000



*[Faint signature]*

1-9-11

ARMY FIELD

UNITED STATES

J-525

70 12935

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 12935

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WALTER JOHNSON

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Church Home &amp; Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

12

25

1970

3:08 a

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Md.

B. COUNTY

3-01

6. SEX

male

7. RACE

negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

10. AGE (In years  
lost birthday)

50

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

404 S. Dallas St.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

19.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

fatty liver

DUE TO, OR AS A CONSEQUENCE OF:

(B)

chronic alcoholism

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

PARTIAL

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

22E. INJURY OCCURRED.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-25-70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

2-9-71

24C. NAME OF CEMETERY

24D. LOCATION (City, town or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 18 1971

25B. NAME OF REGISTRAR

Robert E. Taber, M.D.

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL

MORTUARY SERVICE - BCHD



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

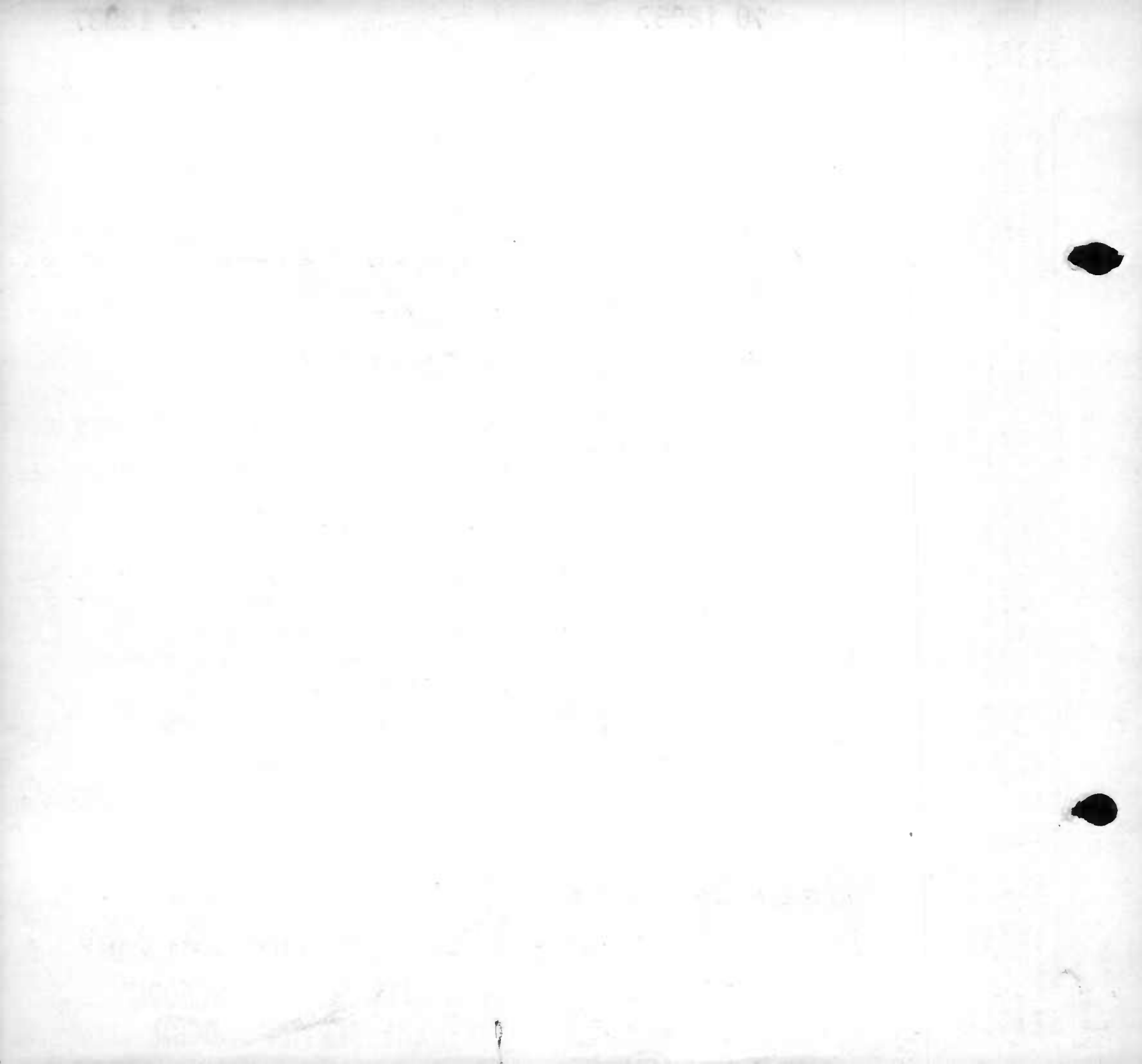
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 12936</u>	
M-252 70 12936		CERTIFICATE OF DEATH			
BIRTH NO. <u>70-23536</u>		1. NAME OF DECEASED (Type or Print) <u>Baby Boy McKenzie</u>			
2. DATE AND HOUR OF DEATH <u>12-22-70</u> <u>11</u> <u>40</u> P. M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 University Hospital</u>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1513</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <u>M.</u> 6. RACE <u>N</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <u>2474 SHIRKEY AVE.</u>			
8. DATE OF BIRTH <u>12-22-70</u> 9. AGE (In years last birthday) <u>3</u>		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u> 10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>—</u>		13. FATHER'S NAME <u>James Sabb</u> 14. MOTHER'S MAIDEN NAME <u>Ernestine McKenzie</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Ernestine McKenzie</u> ADDRESS <u>—</u>	
18. <u>760-21</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>anoxia</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>abruptio placentae</u> DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) <u>maternal hypertension</u>			
19A. DATE OF OPERATION <u>—</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>12-22</u> 19 <u>70</u> to <u>12-22</u> 19 <u>70</u> that <del>the</del> (we) last saw the deceased alive on <u>12-22</u> 19 <u>70</u> and that <del>in</del> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <del>(I)</del> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>X Maria Casavola</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12-22-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Thirco</u>		23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>11/15/71</u>		24B. DATE <u>11/15/71</u>		24C. NAME of CEMETERY or CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL</u>	
24D. LOCATION (City, town, or county) <u>MORTUARY SERVICE - BCHD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 23 1971</u> 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> 25C. FUNERAL DIRECTOR <u>—</u> ADDRESS <u>—</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 12937	
E-363 70-22538		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BABY EDWARDS		7:50 12/7/70 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
42 SIMAI HOSPITAL		Md BALTIMORE 907			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		1605 HONOLULU ST.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
F	N	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12/7/70	21 Hour	0 20 Min
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Md	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
ROBERT EDWARDS		MARGARET COX			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO					
1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		Pulmonary Infection			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Prematurity - 27 weeks gestation			
		(C) CANDIDAS ARREST			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		One kilogram Birth weight			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec 7 1970 to Dec 7 1970, that (I) (we) last saw the deceased alive on Dec 7 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Peter O. Krutovich M.D.		12/7/70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
PETER O. KRUTOVICH M.D.		SIMAI HOSPITAL BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATOR			
	4-19-71	ANATOMY BOARD OF MARYLAND			
25A. DATE REC'D. BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. SIGNATURE OF REGISTRAR	
APR 23 1971		John E. Taylor M.D.			
MORTUARY SERVICE - BCD					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 12938 4	
CERTIFICATE OF DEATH				REG. NO. 70 12938	
S-162 70 12938 BIRTH NO. 70-22600					
1. NAME OF DECEASED (Type or Print) <u>BABY GIRL SPRIGGS</u>		2. DATE AND HOUR OF DEATH <u>12-15-70 2:30 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 Wm. Carey Hospital</u>		C. CITY OR TOWN <u>Balto</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>B</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/15/70</u>		9. AGE (In years last birthday) <u>1</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James Hall</u>		14. MOTHER'S MAIDEN NAME <u>Mary Spriggs</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Dr. Chert 40-99-85</u> ADDRESS <u>(info app)</u>	
18. <u>743.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiopulmonary arrest</u> (B) <u>Underdeveloped Brain Tissue</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>12-16-70</u>		23C. PHYSICIAN'S NAME (Type) <u>MD</u> DEGREE <u>MD</u> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>12-1-1970</u>		24C. NAME OF CEMETERY OR CREMATORY <u>UNIVERSITY HOSP. DISPOSAL</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO, MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher, MD</u>		25C. ADDRESS <u>HOSPITAL DISPOSAL</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				DUPLICATE COPY	
70 12939		CERTIFICATE OF DEATH		REG. NO. 70 12939	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		RIOS, LOUISE		FEBRUARY 8, 1970 10:20AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MARYLAND 21229			PENNSYLVANIA V35 15963		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			WINDBER		YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			1015 PARK LANE		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12 07 08	61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE			PENNSYLVANIA		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JOSEPH TURCATO			LOUISE (BENNETTE)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NONE					AVES. BALTO. MD. 21229
			ST. AGNES HOSP: RECORDS-CATON & WILKENS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
431.9 I			INTRACRANIAL HEMMORRHAGE.		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from FEBRUARY 8 19 70 to FEBRUARY 8 19 70 that (X) (we) last saw the deceased alive on FEBRUARY 8 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (IX) (We) (did) (not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
ZAHEER-KAHN MD.				CATON & WILKENS AVES BALTO, MD 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		2-11-70		St. Mary, Windber, Penna.	
				Windber, Pennsylvania	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 21 1972		Robert E. Fisher, M.D.		Curran Funeral Service, Towson, Md.	

